

Date: 11/07/2007

**CalPERS Health Benefit Service: Vision
Employer Health Event Notification
Notice Processed Date: 11/07/2007**

Agency: 69 Unit: 0 Name: City of Bell

**69 City of Bell
Lourdes Garcia
6330 Pine Ave.
Bell, CA 90201**

CalPERS Employer Health Event Notification

Subscriber Name	SSN #	Eff. Date	Plan Name	Ren	Category	Description	Action
Spaccia-Sheffield, Sean-Tho		01/01/2008	PERSCare LA Are	400	Change Plan	Open Enrollment Plan C	Insert

Total Events - 1

California Public Employees' Retirement System
P.O. Box 942714
Sacramento, CA 94229-2714

HEALTH BENEFITS PLAN
ENROLLMENT FORM
PERS-HBD 12 (Rev. 6/02)

DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input checked="" type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER [REDACTED]	AC C T I O N	LIST ALL PERSONS (including self) TO BE ENROLLED IN:	DATE OF BIRTH			Family Relation ship	C O D E	
	3. SPOUSE'S SOCIAL SECURITY NUMBER - -		17. BASIC PLAN (First) (MI) (LAST) Pier'Angela - SPACCIA	MO.	DAY	Yr.	SELF		
4a. Name Pier'Angela - SPACCIA (First) (MI) (LAST)									
Mailing Address [REDACTED]									
City, State, Zip [REDACTED]									
4b. RESIDENCE ZIP CODE (if different from 4A)									
5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)	6. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female		7. MARRIED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
8. PLAN CODE	9. NAME OF HEALTH PLAN PERS CARE								
10. GROSS PREMIUM \$	11. PRIMARY CARE PHYSICIAN MEDICAL GROUP								
12. PRIOR PLAN CODE	13. PRIOR HEALTH PLAN		AC C T I O N	18. SUPPLEMENTAL PLAN (First) (MI) (LAST)	DATE OF BIRTH			Family Relation ship	C O D E
14. Permitting Event Code 4 0 0	15. Permitting Event Date Mo. Day Yr.	16. EFFECTIVE DATE Mo. Day Yr.			Mo.	Day	Yr.		

19. CHECK ONE
 I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
 I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
 I select to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (See privacy information on reverse of employee copy.)
 Pier'Angela Spaccia
 TELEPHONE NUMBER [REDACTED]
 21. DATE SIGNED
 Mo. Day Year
 9 17 06

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of Action 1. <input type="checkbox"/> New 2. <input type="checkbox"/> Cancel 3. <input checked="" type="checkbox"/> Change (Check) (One)	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION PERS	27. BARGAINING UNIT
28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE 0069	31. UNIT CODE		

32. I hereby certify under penalty of perjury as follows:
 That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made the Board of Administration, California Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER
 [Signature]
 33. Date received
in employing
office
Mo. Day Year
 34. PHONE NUMBER
 (323) 5886211

35. REMARKS
 [Blank]
 Forms
 WHITE - HBD PINK - Agency BLUE - Employee

 * TRANSACTION REPORT BATCH: 20671152 DATE: 10/06/2006 USER: 0131TBAS

 * 4. Change Health Plan

NAME (LAST, SUFFIX, FIRST, MIDDLE)
 Spaccia Fier' Angela

SEX BIRTHDATE OLD BIRTHDATE
 F 09/19/1958

CURRENT ADDRESS
 Domestic Mailing

IN C/O :
 BOX/ST :
 2NDLINE :
 CITY :
 ST/ZIP :
 COUNTRY :
 PHONE:32

APPT START DT TRANSACTION TYPE POSITION STATUS
 4 Change Health Plan

ER CD:69 Bell ORG ID:131

HEALTH COVERAGE

HEALTH EVENT REASON CODE&DESCRIPTION	EVENT DATE	HBO REC DT	HTH EFF DT
400 Open Enrollment Plan Chg	09/01/2006	09/07/2006	01/01/2007

PLAN NAME	PR COVERAGE TYPE	PHYSICIAN
FERSCare LA Area 1		

ELIG CODE	ELIG ZIP	MED GRP	MED GRP DT
1			

SPOUSE SSN	COBRA STRT	COBRA END	QUALIFY SSN	FREN PAY METH	PAY EFF DT
					01/01/2007

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CALPERS HEALTH BENEFIT SERVICES DIVISION
EMPLOYER HEALTH EVENT NOTIFICATION
NOTICE PROCESSED DATE: 02/06/2006

Date: 02/06/2006

Agency: 69 Unit: 0 Name: City of Bell

SUBSCRIBER NAME	SSN #	EFF. DATE	REASON	PLAN NAME	CATEGORY	DESCRIPTION	ACTION
Spacola-Sheffield, Sean-	[REDACTED]	02/07/2006	136	PERSCH LA Area	New Enrollment	COBRA Loss of Dependent Status	INSERT

TOTAL EVENTS: 1

**CalPERS - HEALTH BENEFIT SERVICES DIVISION
HEALTH BENEFIT PLAN ENROLLMENT NOTIFICATION
EMPLOYER NOTICE OF DELETION OF CHILD OVER THE AGE OF 23**

Date: 02/03/2006

City of Bell Agency: 69 Unit: 0

Subscriber Information: 564-27-6697 Spaccia, Pier Angela	Health Plan Information: 321 PERSCh LA Area Deletion Eff: 02/01/2006	Dependent Deleted: Spaccia-Sheffield, Sean-Thomas F 01/15/1983 Male Child
Premium Payment Method: DEDUCTION Currently Covered: SSN	Qualifying Information:	Relationship Self
Name Spaccia, Pier Angela	Date of Birth 08/19/1958	Gender Female Plan Type Basic

 * TRANSACTION REPORT BATCH: 17349158 DATE: 01/31/2006 USER: 0131TBAS

 * 1. New COBRA Health Enrollment

NAME (LAST, FIRST, MIDDLE)
 Spaccia-Sheffield Sean -Thomas F

SSN [REDACTED] SEX M BIRTHDATE 01/15/1983 OLD BIRTHDATE

CURRENT ADDRESS
 Domestic Mailing

IN C/O :
 BOX/ST : [REDACTED]
 2NDLINE :
 CITY :
 ST/ZIP :
 COUNTRY :
 PHONE: - X

APPT START DT TRANSACTION TYPE POSITION STATUS
 17 New COBRA Health Enrol im

ER CD:69 Bell ORG ID:131

HEALTH COVERAGE

HEALTH EVENT REASON CODE&DESCRIPTION	EVE NT DATE	HBO REC DT	HTH EFF DT
136 COBRA Loss of Dependent Status	02/ 01/2006	01/23/2006	02/01/2006

PLAN NAME	PR COVERAGE TYPE	PHYSICIAN
PERSCh LA Area-3 1	Basic	

ELIG CODE	ELIG ZIP	MED GRP	ME D GRP DT
1			

SPOUSE SSN	COBRA STRT	COBRA END	QUALIFY SSN	PREM PAY METH	PAY EFF DT
	02/01/2006	02/01/2009	6060309 50	COBRA	02/01/2006

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CALPERS HEALTH BENEFIT SERVICES DIVISION
EMPLOYER HEALTH EVENT NOTIFICATION
NOTICE PROCESSED DATE: 01/05/2006

Date: 01/05/2006

Agency: 69 Unit: 0 Name: City of Bell

SUBSCRIBER NAME	SSN #	EFF. DATE	REASON	PLAN NAME	CATEGORY	DESCRIPTION	ACTION
Spaccia, Pier' Angela	[REDACTED]	02/01/2006	602	PERSCh LA Area	Delete Dependent	28 year old delete	INSERT

TOTAL EVENTS: 1

OCT.24 '2003 07:52 818234317

Blue Cross of California
MEMBER CLAIM FORM

#6378 P.003/003



CLAIM CONTROL NUMBER • FOR BLUE CROSS USE ONLY
--



Blue Cross of California Member of the Blue Cross Association
Division of California Health Insurance Agency

PATIENT INFORMATION

NAME: SPACCIA Pier' ANGELA
LAST FIRST MIDDLE

DATE OF BIRTH: 09 19 58
MO DAY YR

SEX: F
M F

RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD

OCCUPATION: ASST. TO CAO

EMPLOYER: CITY OF BELL

IS PATIENT COVERED BY MEDICARE? YES NO

IF "YES" MEDICARE I.D. NUMBER: _____

EFFECTIVE DATES: (MEDICARE) PART A: MO DAY YR; PART B: MO DAY YR

PATIENT WAS TREATED FOR: INJURY ILLNESS PREGNANCY

DATE OF INJURY, ONSET OF ILLNESS OR PREGNANCY: MO DAY YR

WAS CONDITION RELATED TO EMPLOYMENT? YES NO

DESCRIBE BRIEFLY PATIENT'S ILLNESS OR INJURY... IF INJURY, HOW IT OCCURRED.
 DIFFICULTY BREATHING
 ALLERGIC REACTION

OTHER INSURANCE INFORMATION

DOES PATIENT HAVE OTHER HEALTH INSURANCE? YES NO

POLICY HOLDER NAME: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

EFFECTIVE DATE: MO DAY YR; POLICY NUMBER: _____

MEMBER INFORMATION

I.D. NUMBER: _____

GROUP NO.: _____

NAME: SPACCIA Pier' ANGELA
LAST FIRST MIDDLE

STREET ADDRESS: _____

CITY: _____

NEW ADDRESS YES NO • IF YES, HAVE EMPLOYER SIGN THIS FORM.

MEMBER'S MARITAL STATUS IF OTHER COVERAGE EXISTS:
 SINGLE MARRIED LEGALLY SEPARATED DIVORCED WIDOWED

COMPLETE IF YOU ARE MARRIED:

NAME OF SPOUSE: _____ DATE OF BIRTH: MO DAY YR; SPOUSE'S SOCIAL SECURITY NUMBER: _____

IS YOUR SPOUSE EMPLOYED? YES NO
 IF YES, NAME AND LOCATION OF SPOUSE'S EMPLOYER: _____

EMPLOYER'S NAME AND ADDRESS: _____

NAME OF SPOUSE'S GROUP HEALTH PLAN: _____

IF DIVORCED OR LEGALLY SEPARATED, AND CLAIM IS FOR A DEPENDENT CHILD, PLEASE FURNISH THE FOLLOWING:

OTHER PARENT'S NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

EMPLOYER'S NAME AND ADDRESS: _____

REFERRING PHYSICIAN
 If the bill is from an Audiologist or Occupational, Physical, Respiratory or Speech Therapist, what is the name of the physician who ordered the service?
 Dr. _____

Please read both sides of this form carefully. Use a separate Patient Claim Form for EACH PATIENT. Please PRINT or TYPE. YOUR COOPERATION IN COMPLETING ALL ITEMS ON THE CLAIM FORM AND ATTACHING ALL REQUIRED DOCUMENTATION WILL HELP EXPEDITE QUICK AND ACCURATE PROCESSING OF YOUR CLAIM.

TOTAL NUMBER OF BILLS ATTACHED: 1

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

PATIENT'S SIGNATURE: Pier' Angela Spaccia
 DATE: _____

OCT. 24 '2003 07:52 8182343172

Blue Cross of California

#6378 P.002/003

ABOUT THIS FORM**Dear PERSCare / PERS Choice Member:**

Usually, all providers of health care will bill us directly for services to you and your enrolled dependents.

This is the preferred procedure—you are not bothered with claim forms, and we often need more details than are ordinarily provided on bills to patients.

But sometimes a physician may not bill us. Or an ambulance company, for example, may send the bill directly to you. In either instance, we have no way of knowing about your claim.

This is why this form was developed. Use it to notify us of any covered health service for which we have not already been billed. You are urged to send us each bill immediately upon receipt.

Please read the instructions about how to use this form. It is for your convenience.

We are happy to serve you.

HOW TO USE THIS FORM

- Please complete a separate claim form for each patient.
- Attach original medical bills. We suggest that you keep copies for your records.
- If you are enrolled in Medicare, attach a clear copy of the Explanation of Benefits you receive from Medicare.
- If Blue Cross is not your prime carrier, please include an Explanation of Benefits from your other carrier.

WHEN TO USE THIS FORM

- Each time you submit bills, including those for ambulance services and appliances not usually billed directly to Blue Cross.
- Do not use this form for bills which are being sent directly to Blue Cross by the hospital, doctor, or laboratory.

BILLS MUST BE ITEMIZED

Cancelled check, cash register receipts and non-itemized "balance due" statements cannot be processed. Each itemized bill must include:

1. Name and address of provider (doctor, hospital, laboratory, or ambulance service, etc.)
2. Name of patient
3. Date of service
4. Amount charged for each service
5. Diagnosis or reason for treatment

Write your Group Number and your PERSCare or PERS Choice ID Number on the face of each bill.

THE FOLLOWING INFORMATION MUST ALSO BE INCLUDED ON BILLS FOR THESE ITEMS:**REGISTERED AND LICENSED VOCATIONAL NURSES:**

- Hours and dates of service
- Location of service (residence or name of hospital)
- Written documentation of physician's referral (must include the state license number, plan of treatment and estimated duration of treatments)

PROSTHETIC DEVICES, APPLIANCES OR DURABLE MEDICAL EQUIPMENT:

- Doctor's orders or prescriptions
- Purchase price

AMBULANCE

- Pick-up and delivery points
- Number of miles

WHERE TO SEND COMPLETED CLAIM FORMS

Mail completed form plus itemized bills to:
 Blue Cross of California
 PO Box 4386
 Woodland Hills, CA 91369-4386

CLAIM INFORMATION

Claims or benefit questions will be answered by calling
 1-877-PERSPPO (1-877-737-7776).

For prescription drug reimbursement claim forms, please call
 Merck-Medco Member Services at 1-800-316-9178.

TECHNIMED-VERNON INDUSTRIAL
 MEDICAL CENTER
 3364 E. SLAUSON AVENUE
 VERNON, CA. 90058
 323-584-7242

Employer: CITY OF BELL
 6330 PINE AVENUE
 BELL, CA 90201

Injury Date: 09/15/03

Case #:
 Add Case #:

Patient	Responsible Party
ANGELA SPAECIA	CITY OF BELL
Account # 1-08196	6330 PINE AVENUE
Ins Type: Work Comp	BELL, CA 90201
	Attn: ALEX VELOZ

STATEMENT OF ACCOUNT

Date	Diag	MD	Loc	Code	Description Of Service	Amount
09/15/03	995.3	FG	3			76.50
09/15/03	995.3	FG	3			4.50
09/15/03	995.3	FG	3			
09/15/03	995.3	FG	3			15.38
09/15/03	995.3	FG	3			12.00
09/15/03	995.3	FG	3			20.00

Billing Date	Last Payment Amount	Date	Current	Over 60	Over 90	Over 120	Total
09/18/03							128.38

Make Checks Payable To
 TECHNIMED-VERNON INDUSTRIAL MEDICAL CENTER

Federal Tax ID Number:
 95-4001916

State License # G48455

Please
 Pay This
 Amount

128.38

**DOCTOR'S FIRST REPORT
OF OCCUPATIONAL INJURY
OR ILLNESS**

**1. INSURER: CO & LEE
1470 SO. VALLEY VISTA DR. #230
DIAMOND BAR, CA 91765**

State of California

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employers workers' compensation insurance carrier or the self-insured employer. Failure to file a timely doctor's report may result in a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of this report to Division of Labor Statistics and Research, PO Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

2. EMPLOYER NAME: CITY OF BELL		
3. Address: City, State		
4. Nature of Business:		
5. PATIENT: ANGELA SPAECIA	6. Sex: Female	
8. Address: N/A	7. Birth:	
CSZ:	9. Tele:	
10. Occupation: ASST. CAO	11. SS #: Not On File	
12. Injured At: PREMISES	County: LA	
CSZ:		
13. Date & Hour of Injury: 09/15/2003	16. Pat Prev Treated: NO	
14. Date Last Worked: 09/15/2003		
15. Date & Hour of 1st Exam: 09/15/2003 10:50 AM		
17. DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED:		
18. SUBJECTIVE COMPLAINTS:		
19. OBJECTIVE FINDINGS:		
a. Physical Examination:		
b. X-Ray & Lab: NONE.		
20. DIAGNOSIS: Chemical or toxic compounds involved?	ICD-9 Code:	
21. Are Findings and Diagnosis Consistent with Patient's Account? If NO, explain:		
22. Any other Current Condition that will Impede/Delay Recovery? If YES, explain:		
23. TREATMENT RENDERED:		
24. Further Treatment:		
25. If Hospitalized:	Date Admitted:	Est Duration: 0 days
City, State, Zip:	Est Stay:	0 days
26. WORK STATUS: Perform Usual Work? If NO, pat can return to: Usual Work: Modified Work:		
Specify Restrictions: PER PRIVATE PHYSICIAN.		
Doctor's Name: FRANK D. GONZALES, M.D., MPH	State Lic #: G48455	
TECHNIMED-VERNON INDUSTRIAL	IRS No: 95-4001916	
7364 E. SLAUSON AVENUE	Tele #: 323-584-7242	
VERNON CA. 90058		
Signature:	Report Dated: 09/16/2003	

Any person who makes or causes to be made any knowingly false or fraudulent material statements or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

CITY CLERK-CITY OF BELL
SEP 02 2003

RECEIVED
08/28/2003

**CALPERS HEALTH BENEFIT SERVICES DIVISION
EMPLOYER HEALTH EVENT NOTIFICATION
NOTICE PROCESSED DATE: 08/28/2003**

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Agency: 69 Unit: 0 Name: City of Bell

SUBSCRIBER NAME	SSN #	EFF. DATE	REASON	PLAN NAME	CATEGORY	DESCRIPTION	ACTION
Spaccia, Pitar' Angela	[REDACTED]	07/01/2003	212	PERSCH-BC	Add Dependent	Add Dependant Other	INSERT

TOTAL EVENTS: 1

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CALPERS HEALTH BENEFIT SERVICES DIVISION
EMPLOYER HEALTH EVENT NOTIFICATION
NOTICE PROCESSED DATE: 08/04/2003

Date: 08/04/2003

Agency: 69 Unit: 0 Name: City of Bell

SUBSCRIBER NAME	SSN #	EFF. DATE	REASON	PLAN NAME	CATEGORY	DESCRIPTION	ACTION
Spaccio, Pier' Angela	[REDACTED]	07/01/2003	100	PERSCH-BC	New Enrollment	Time Base & Tenure	INSERT

TOTAL EVENTS: 1

 * 2. New Health Enrollment

NAME (LAST, FIRST, MIDDLE)
 Spaccia Pier' Angela

SSN	SEX	BIRTHDATE	OL D BIRTHDATE	DEATHDATE
[REDACTED]	F	09/19/1958		

CURRENT ADDRESS

IN C/O :
 BOX/ST :
 2NDLINE:
 CITY :
 ST/ZIP :
 COUNTRY:
 PHONE: - X EE ID#:

APPT START DT	TRANSACTION TYPE	POSITION STATUS
	1 New Health Enrollment	

ER CD:69 Bell ORG ID:131

HEALTH COVERAGE

HEALTH EVENT REASON CODE&DESCRIPTION	EVE NT DATE	HBO REC DT	HTH EFF DT
100 Time Base & Tenure	06/ 30/2003	06/30/2003	06/30/2003

PLAN NAME	PR COVERAGE TYPE	PHYSICIAN
PERSch-BC-222	1 Basic	

ELIG CODE	ELIG ZIP	MED GRP	ME D GRP DT
1		001	

SPOUSE SSN	COBRA STRT	COBRA END	QUALIFY	SSN	PREM PAY METH	PAY EFF DT
					Standard	06/30/2003

CalPERS - ACES

Page 1 of 1

CalPERS - ACES
New Connections**Batch Confirmation****Confirmation****Your batch was successfully submitted to CalPERS.****Organization Name: City of Bell****Username: 0131TBAS****Tracking ID: 5557714****Date/Time Received: 07/07/2003 08:14 AM****Number of Transactions: 2****E-mail address to send processing****summary to: tdiaz@cityofbell.org**



Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94223-2714

HEALTH BENEFIT PLAN
ENROLLMENT FORM
PERS-HBD-12 (Rev. 10/93)

DO NOT SEND MEDICAL
CLAIMS TO THIS ADDRESS

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One) <input type="checkbox"/> a. NEW enrollment <input type="checkbox"/> b. CHANGE of coverage <input type="checkbox"/> c. CANCEL all coverage	2. SOCIAL SECURITY NUMBER /	20. LIST ALL PERSONS (including self) TO BE ENROLLED IN: 17. BASIC PLAN	DATE OF BIRTH			Family Relationship SELF	CODE
	3. SPOUSE'S SOCIAL SECURITY NUMBER		(FIRST)	(MID)	(LAST)		
4A. Name Pier'Angela — Spaccia		4B. RESIDENCE ZIP CODE (if different from 4A)		5. <input type="checkbox"/> Please check if Permanent Intermittent Employee (applies to active State employees only)		6. SEX <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	
7. MARRIED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. PLAN CODE 2221		9. NAME OF HEALTH PLAN PERS Choice		10. GROSS PREMIUM \$	
11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP		12. PRIOR PLAN CODE		13. PRIOR HEALTH PLAN		14. PERMITTING EVENT CODE	
15. PERMITTING EVENT DATE Mo. Day Year		16. EFFECTIVE DATE Mo. Day Year 01		18. SUPPLEMENTAL PLAN		DATE OF BIRTH Mo. Day Yr.	

19. CHECK ONE

I DO NOT wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.

I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependants listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.

I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse)
Pier'Angela Spaccia

21. DATE SIGNED
Mo. Day Year
6. 30. 03

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One) <input type="checkbox"/> New <input type="checkbox"/> Cancel <input type="checkbox"/> Change	24. PAY PERIOD Month Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE		

32. I hereby certify under penalty of perjury as follows: SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office
Mo. Day Yr.

34. PHONE NUMBER
()

35. REMARKS
_____ of _____ Forms

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22830 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.



California Public Employees' Retirement System
Health Benefit Services Division
P.O. Box 942714; Sacramento, CA 94229-2714
(800) 237-3345

Declaration of Health Coverage
HB-12A (01/01/98)

(INSTRUCTIONS ON REVERSE)

EMPLOYEE INFORMATION SOCIAL SECURITY NUMBER	NAME/	(FIRST)	(MIDDLE)	(LAST)
[REDACTED]	Fier	Angela	-	Spacia
PART A <input type="checkbox"/> I elect to enroll myself and all eligible dependents.				
PART B-1 <input checked="" type="checkbox"/> I elect to enroll myself. My eligible dependents have other health insurance coverage.		If you or your dependents lose health insurance coverage, you can enroll in the CalPERS Health Benefits Program. You must request enrollment with 60 days from the date you lose coverage.		
PART B-2 <input type="checkbox"/> I elect to enroll myself and eligible dependents. I also have eligible dependents who have other health insurance coverage.		If you do not request enrollment within 60 days, you or your dependents must wait at least 90 days or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.		
PART C-1 <input type="checkbox"/> I decline enrollment for myself and my eligible dependents because we have other health insurance coverage.				
PART C-2 2. <input type="checkbox"/> I decline enrollment for myself and/or my eligible family members for reasons other than having health insurance coverage.		You can request enrollment for yourself and/or your dependents at any time. You must wait at least 90 days after you request enrollment or until the next Open Enrollment Period before you can enroll in the Program. Your effective date of coverage will be the first of the month following the 90 day waiting period or the Open Enrollment effective date.		

PART B: If you are currently enrolled in the Health Benefits Program and you acquire new dependents or if a court orders health coverage for your dependent, you can add your new dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

PART C: If you are not currently enrolled in the Health Benefits Program and you acquire new dependents as a result of marriage, birth, adoption, or placement for adoption, or if a court orders health coverage for your dependent, you can enroll yourself and dependents. See your Health Benefits Officer or visit your personnel office for applicable time limits.

Special rules apply to retirement and death. Please read the back of this form carefully.

Fier Angela Spacia
Member's Signature
HB-12A (01/98)

6/30/03
Date Signed
Original: Employee's Personnel File

[Signature]
Health Benefits Officer's Signature
Copy: Employee

INSTRUCTIONS - DECLARATION OF HEALTH COVERAGE (HB-12A)

Employee Information	Complete with the appropriate employee information.
PART A:	Mark this box if you are: a) Enrolling in the Health Benefits Program and have no dependents, or b) Enrolling yourself and ALL eligible dependents in the Health Benefits Program.
PART B-1:	Mark this box if you are: a) Enrolling yourself only, your dependents have other health insurance coverage, or b) Canceling your dependents' coverage because they have other health insurance coverage.
PART B-2:	Mark this box if you are: a) Enrolling yourself and SOME of your dependents, your other dependents have health insurance coverage, or b) Canceling coverage for some of your dependents because they have other health insurance coverage.
PART C-1:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage, you have no dependents and you have other health coverage, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents and you have other health insurance coverage.
PART C-2:	Mark this box if you are: a) Declining enrollment or canceling your health insurance coverage for reasons other than having health insurance coverage and you have no dependents, or b) Declining enrollment or canceling your health insurance coverage for yourself and eligible dependents for reasons other than having health insurance coverage.

IMPORTANT: It is your responsibility to notify your personnel office when there are any changes in your family situation. Changes include marriage, acquisition of a dependent child, divorce, legal separation, and death. Failure to notify your personnel office may result in adverse consequences.

Special rules for retirement and death:

Consider these points as you decided whether to enroll, decline, or cancel enrollment for yourself or dependents.

- If you are not enrolled in a CalPERS-sponsored health plan on the date you separate employment, you will not be eligible for health benefits into retirement.
- If your retirement date is over 120 days from your separation date, you will not be eligible for health benefits into retirement.
- If you die and your eligible family members are not enrolled on your CalPERS-sponsored health plan at that time, they will not be eligible for continued enrollment in a CalPERS-sponsored health plan if they qualify for monthly survivor benefits.

PERS Membership

CalPERS - ACES

Page 1 of 1

View Participant Information

Participant Inquiry



SSN: [REDACTED]

As Of: 05/27/2006

Name: Pier' Angela Spaccia

Birth Date: 09/19/1958

Gender: Female

Member: Yes

Retiree: No

Death Date:

HBO Phone: [REDACTED]

Dependent Information

SSN	Name	Birth Date	Relationship	Enrl Eff Date
-----	------	------------	--------------	---------------

Gender:

Disabled Dependent Certification Date:

Coverage Type:

Certification Expiration Date:

Pending Review Date:

 * TRANSACTION REPORT BATCH: 5557714 DAT E: 07/07/2003 USER: 0131TBAS

 * 1. New PERS Enrollment

NAME (LAST, FIRST, MIDDLE)
 Spaccia Pier' Angela

SSN	SEX	BIRTHDATE	OL D BIRTHDATE	DEATHDATE
[REDACTED]	F	09/19/1958		

CURRENT ADDRESS
 Domestic Mailing

IN C/O :
 BOX/ST :
 2NDLINE:
 CITY :
 ST/ZIP :
 COUNTRY:
 PHONE: - X EE ID#:

APPT START DT	TRANSACTION TYPE	POSITION STATUS
06/30/2003	11 New PERS Enrollment	Active

ER CD:69 Bell ORG ID:131

COVERAGE GROUP	OPT	RETIRE SYSTEM	POSITION #	CBU
70002 Misc W/SS MOD	N	Public Employe		



P.O. Box 942709
Sacramento, CA 94229-2709
Telephone (888) 225-7377
FAX (916) 326-3267
TDD (916) 326-3240

(Please PRINT or TYPE clearly)

INCOMPLETE OR IMPROPERLY COMPLETED FORMS MAY BE RETURNED TO YOU

Member Action Request

1 SOCIAL SECURITY NUMBER [REDACTED]		2 Current Name (First, Middle, Last) PIER'ANGELA SPACCIA		3 Daytime Phone Number [REDACTED]	
4 Date of Birth MM DD YYYY 07 01 1968		5 Gender <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown		6 Former Name - For name changes only (First, Middle, Last)	
7 Mailing Address: In Care of (if applicable): Street/P.O. Box: Additional Address Line: City: State: CA ZIP Code: 95820				8 Remarks (pertaining to CalPERS)	
				9 Employer Name City of Bell	
10 Effective Date of Action MM DD YYYY 07 01 2003		11 Subject to Section 20306 <input type="checkbox"/> Yes <input type="checkbox"/> No		12 Employer Code 0069	
		13 District Code (schools only)		14 Hire Date MM DD YYYY 07 01 2003	

15 Type of Action (check all boxes that apply for this Effective Date; if none apply, indicate action needed in "Remarks" [#8] above):

- | | | |
|---|---|--|
| A. <input checked="" type="checkbox"/> Appointment/Membership | E. <input type="checkbox"/> Military Leave | I. <input type="checkbox"/> Alternate Retirement Plan (G.C. 20306) |
| B. <input type="checkbox"/> Return from Leave | F. <input type="checkbox"/> Worker's Comp Leave | J. <input type="checkbox"/> Name Change |
| C. <input type="checkbox"/> Separation, Permanent | G. <input type="checkbox"/> Sabbatical Leave | K. <input type="checkbox"/> Address Change |
| D. <input type="checkbox"/> Separation, Temp (≥ 2 months) | H. <input type="checkbox"/> Maternity/Paternity Leave | L. <input type="checkbox"/> Coverage Group Change |

16 Coverage Group	17 Job/Position Title ASSISTANT TO CAO	18 ½ @ 55 Formula Cont. Rate: %
-------------------	---	--

19 - This person is an Optional Member (e.g., "Elected Officer," "Legislative Employee") who is electing membership.
(Please attach appropriate election form AESD-3, AESD-59, or AESD-229)

20 BASIS FOR MEMBERSHIP QUALIFICATION: (Optional informational field. Check appropriate box.)

- | | |
|-------------------------------------|--|
| <input checked="" type="checkbox"/> | Full-Time for > 6 months |
| <input type="checkbox"/> | Part-Time for ≥ 20 hours for 1 year or more |
| <input type="checkbox"/> | Indeterminate; at least 20 hours a week for 1 year or more |
| <input type="checkbox"/> | Has completed 1,000 hours or 125 days in fiscal year |
| <input type="checkbox"/> | Person is already a PERS member |

21 Form Completed By:

THERESA DIAZ Management Analyst

(Name & Title)

323-588-6211

323-771-9473

04/11/03

(Telephone Number)

(Fax Number)

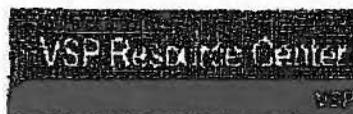
(Date)

[Signature]
(Signature of Certifying Officer)

7/1/02

(Date)

Vision Plan Enrollment



VSP Home | About VSP | VSP WebMaster Learning Source | Find a Dealer | Contact Us



Member Detail

Help

Search for a Member

Last Name or Member ID:

SEARCH

Add/Reinstate a Member

Member ID:

Add a Member

Reinstate a Member

GO

Member Added

Client Information

Client (Group) Number

00237070

Division - Class

0002-0001

Member Information

Member ID:

Member Name: SPACCIA, PIER'ANGEL

Original Effective Date: Jun 2003

Birth Date: 19 Sep 1958

Coverag

Gender:

Female

Address:

VIEW RECORDS

UPDATE

TERMINATE

TRANSFER

- VSP Resource Center Home
- Eligibility Management Home
- Client Detail
- Member List
- Your Account Team
- Tell Us What You Think
- Log Off

Cobra Acknowledge

CITY OF BELL



FACSIMILE TRANSMITTAL SHEET

TO: Nicole	FROM: Rebecca Valdez
COMPANY: Cal-Pers	DATE: April 23, 2008
FAX NUMBER: (916) 795-0491	TOTAL NO. OF PAGES INCLUDING COVER: 5
PHONE NUMBER:	SENDER'S TELEPHONE NUMBER: 323-588-6211, ext. 217
RE: Sean-Thomas Spaccia-Sheffield	YOUR REFERENCE NUMBER:

URGENT
 FOR REVIEW
 PLEASE COMMENT
 PLEASE REPLY
 PLEASE RECYCLE

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS PRIVILEGED AND CONFIDENTIAL INFORMATION INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED BELOW. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISSEMINATION, DISTRIBUTION OR COPYING OF THIS TELECOPY IN ERROR PLEASE IMMEDIATELY NOTIFY US BY TELEPHONE AND RETURN THE ORIGINAL MESSAGE TO US AT THE BELOW ADDRESS VIA UNITED STATES POSTAL SERVICE. THANK YOU.

Melinda @ Blue Cross

6330 PINE AVENUE
 BELL, CALIFORNIA 90201
 (323) 588-6211
 (323) 771-9473 FAX



Office of Employer and Member Health Services
 P.O. Box 942714
 Sacramento, CA 94229-2714
 888 CalPERS (or 888-225-7377)
 TDD - (916) 795-3240; FAX - (916) 795-1277

Medical

69
 Bell
 Notice 28
 PA Former Employee

11/07/2007

Sean Thomas F Spaccia-Sheffield

The following health plan change has been processed:

New Plan: PERSCare LA Area Effective Date: 01/01/2008

This record represents your COBRA enrollment as of this action's effective date.

Please note that your COBRA coverage will terminate on 01/31/2009.

PLAN: PERSCare LA Area

PAYMENT METHOD: COBRA

PERSONS ENROLLED IN BASIC:

NAME	BIRTHDATE	RELATIONSHIP	ADDITIONAL INFORMATION
Sean-Thomas F Spaccia-Sheffield	01/15/1983	Self	

PERSONS ENROLLED IN SUPPLEMENT/MANAGED MEDICARE: NONE

For medical claims status, benefit information, identification card, booklets, or claim forms contact:

**PERSCare LA Area
P. Box 629**

**Woodland Hills, CA 91365-0629
877-737-7776**

Route To:

BC LIFE & HEALTH INSURANCE
P.O. BOX 60007
LOS ANGELES, CA

90060-0007



1 of 3
49750

An Independent Licensee of the
Blue Cross Association



015564
#BUNCRXF
#CALM1004B0WE00988
SEAN-THOMAS F SPACCIA-SHEFFIE

APRIL 12, 2008
Id No: 693A71109
Group Number: KB090F

K013584030101*

Dear Member:

Federal law may affect your health coverage if you are enrolled, or become eligible to enroll, in health coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifies the circumstances under which coverage may be excluded for medical conditions that are present before you enroll. Under the law, a pre-existing condition exclusion generally may be imposed only for a limited period of time. This exclusion period is reduced by your prior health plan coverage.

The enclosed Certificate of Group Health Plan Coverage shows evidence of your prior group health plan coverage under BC LIFE & HEALTH INSURANCE.

This Certificate explains your rights under federal law in regard to:

- * Offsetting pre-existing condition exclusions with creditable coverage
- * Special enrollments in another health plan
- * No discrimination based on a health factor
- * Individual (guarantee issue) health coverage

Please read this information carefully and keep it for future reference. If you have questions about this Certificate or any of the information it contains, please call the telephone number listed on the Certificate.

Sincerely,

BC LIFE & HEALTH INSURANCE.



... ..

2 of 3
40751An Independent Licensee of the
Blue Cross Association**IMPORTANT - KEEP THIS CERTIFICATE**

This certificate is evidence (or proof) of your prior health coverage under this plan, and for any person listed below. Under a federal law known as HIPAA you may need this evidence:

1. to reduce a pre-existing condition exclusion period under another plan,
2. to exercise your right to special enrollment in another plan, or
3. to get certain types of individual health coverage, commonly referred to as "guarantee issue" coverage, even if you have health problems.

Separate certificates will be furnished if information is not identical for the participant and each beneficiary. Additionally, this form includes educational information intended to help you understand your rights under HIPAA.

Date Certificate Issued: 04/12/2008
 This certificate has been issued by: BC LIFE & HEALTH INSURANCE.
 P.O. BOX 629
 WOODLAND HLS , CA 91365
 (877) 737-7776
 Participant/Subscriber's Name: SEAN-THOMAS F SPACCIA-SHEFFIE
 Participant/Subscriber's Address:

ID Number: 693A71109
 Group Health Plan Name: PERSCARE-CALPERS CA REGION TWO (LA
 For more information about this Certificate, please call: (800) 352-2238

Name	Waiting Period*	Date Coverage Began	Date Coverage End	Is Coverage Continuing?	18 Months Creditable Coverage?
SEAN-THOMAS F SPACCIA-SHEFFIE	02/01/06	02/01/06	04/01/08	N	Y

* For Coverage provided through an employer, this is the date the waiting period begins (usually the date of hire). This date is used to mark the end of a prior break in coverage. However, the period of time between this date and the date coverage begins does not count toward creditable coverage. Note that in some situations, such as enrollment at a time other than when you are first eligible or if your coverage is transferred when your employer changes carriers, this date may not apply.

013584030200



**Your Rights Under Federal Law
Educational Information About the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

You Have the Right to Offset Pre-existing Condition Exclusions With Creditable Coverage. Some group health plans will not give you coverage for medical conditions that were present before you were enrolled in their plan. These restrictions are known as pre-existing condition exclusions.

A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within 6 months before your enrollment date. Your enrollment date is either:

1. Your first day of coverage under the plan, or
2. If your plan has a waiting period before your health coverage becomes effective, your enrollment date is the first day of your waiting period. (typically, your first day of work).

Your new plan administrator can confirm your enrollment date in the new group health plan.

A pre-existing condition exclusion can last up to 12 months after your enrollment date, unless you are a late enrollee. A late enrollee is a person who did not enroll within 31 days after first becoming eligible for coverage or who enrolled during a special enrollment period (see below). For late enrollees, the pre-existing exclusion period can last up to 18 months. (Please note that these timeframes may be different in states that provide additional protections. See "States Have Flexibility", below.)

Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion on your health plan coverage, the length of the exclusion's time period must be reduced (or offset) by the amount of your prior creditable coverage. You can use up to 18 months, of creditable coverage, including the coverage shown on this certificate, to offset a pre-existing condition exclusion time period. Thus, you need this "Certificate of Prior Health Plan Coverage" to prove your creditable coverage. However, if at any time you went for 63 days or more without any coverage (called a break in coverage), a plan may not have to count the coverage you had before the break. (Please note that the maximum break in coverage may be different in states that provide additional protections. See "States Have Flexibility", below.)

* Creditable coverage includes group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), short-term medical plans, Indian health service plans, military health plans, public health plan and coverage through high-risk pools and the Peace Corps.

3 of 3
40752An Independent Licensee of the
Blue Cross Association

* Creditable coverage does not include accident-only plans; liability, auto, disability income or worker's compensation insurance; specific-disease plans; hospital supplemental plans; Medicare supplemental plans; long-term-care plans; credit-only insurance; on-site medical clinic coverage; and limited-scope dental or vision coverage.

* Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate of past coverage, talk to your new plan administrator.

Therefore, once your coverage ends, you should try to obtain other health plan coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length or any pre-existing condition exclusion if you enroll in another plan.

You Have the Right to Get Special Enrollment in Another Plan: Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.

Therefore, once your coverage ends, if you are eligible for coverage in another plan, (such as a spouse's plan), you should request special enrollment as soon as possible.

You Have the Right to Not Be Discriminated Against Based on a Health Factor: Under HIPAA, a group health plan may not keep you (or your dependents, such as spouse and/or children) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

You Have the Right to Individual ("Guarantee Issue") Health Coverage. Under HIPAA, if you are an eligible individual, you have the right to buy certain individual (nongroup) health policies without pre-existing condition exclusions or, in some states you have the right to buy coverage through a high-risk pool. This means you will not have to complete a health statement and meet medical underwriting requirements, and you will not have a waiting period for coverage of pre-existing conditions. The right to buy individual coverage is the same whether you are laid off, terminated from employment, or voluntarily leave your job.

To be an eligible individual, you must meet the following requirements:

- * You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- * Your most recent coverage was under a group health plan (which can be shown by this certificate);

X013864030300#



- * Your group coverage was not terminated because of fraud or non-payment of premiums;
- * You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- * You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

If you meet these criteria, you may use this form as evidence of creditable coverage when you apply for HIPAA-required individual coverage.

If you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

States have flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications - ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Elms, or <http://www.cms.hhs.gov/hipaal>.

C
**GROUP CONTINUATION
 COVERAGE**

**CONSOLIDATED OMNIBUS BUDGET
 RECONCILIATION ACT "COBRA"**
 PERS-HSD-85 (Rev 5/89)

PERS USE ONLY -- DOCUMENT REFERENCE NUMBER

PUBLIC EMPLOYEES' RETIREMENT SYSTEM
 Office of Employer and Member Health Services
 P.O. Box 842714
 Sacramento, CA 94229-2714
 (888) CalPERS (225-7377)
 TDD - (916) 795-3240 FAX (916) 795-1277

INSTRUCTIONS FOR COMPLETING THIS FORM ARE ON THE REVERSE SIDE. PLEASE TYPE

PART A: ORIGINAL QUALIFYING EVENT AND DATES

1. Type of Action <input type="checkbox"/> NEW <input checked="" type="checkbox"/> Change	2. QUALIFYING EVENT <input type="checkbox"/> EMPLOYMENT SEPARATION/TIMEBASE REDUCTION <input type="checkbox"/> DIVORCE/LEGAL SEPARATION <input type="checkbox"/> CHILD CEASES TO BE A DEPENDENT <input type="checkbox"/> DEATH OF AN EMPLOYEE/RETIREE <input type="checkbox"/> DEPENDENT CONTINUATION - ORIGINAL ENROLLEE ELIGIBLE FOR MEDICARE	3. EVENT DATE	4. COBRA ENROLLMENT PERIOD	
			FROM	TO

PART B: ENROLLEE INFORMATION

5. COBRA ENROLLEE (MAY BE DIFFERENT THAN SUBSCRIBER) SOCIAL SECURITY NUMBER	6. SUBSCRIBER (EMPLOYEE/RETIREE) SOCIAL SECURITY NUMBER
NAME Sean Thomas Spaccia	NAME Pier'Angela Spaccia
ADDRESS	
CITY	

PART D: DEPENDENT INFORMATION

Day Phone	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LIST ALL PERSONS (including self) TO BE ENROLLED IN: (FIRST) (MI) (LAST)	DATE OF BIRTH			FAMILY RELATIONSHIP
BIRTHDATE 01/15/83	SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE		NO.	DAY	YR	
PART C: CARRIER INFORMATION						SELF
7. NAME AND ADDRESS OF HEALTH PLAN						
PLAN CODE:	PREMIUM: \$					
PHONE:						

PART E: ENROLLMENT CHANGES

9. NAME OF PRIOR HEALTH PLAN	11. PERMITTING EVENT CODE	12. PERMITTING EVENT DATE	13. EFFECTIVE DATE OF CHANGE
10. PRIOR PLAN CODE			01

PART F: ELECTION CERTIFICATION

14. I AGREE TO PAY THE PREMIUM FOR THE COVERAGE DIRECTLY TO THE CARRIER LISTED ABOVE. I UNDERSTAND THAT I AM REQUIRED TO SEND THE INITIAL PAYMENT PRIOR TO EFFECTIVE DATE OF ENROLLMENT AND AGREE TO MAKE FUTURE PAYMENTS IN A TIMELY MANNER AS REQUIRED BY THE CARRIER. I UNDERSTAND THAT FAILURE TO PAY THE PREMIUM WILL RESULT IN AUTOMATIC TERMINATION OF COVERAGE. I CERTIFY THAT THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY.

Sean Spaccia
 SIGNATURE OF COBRA ENROLLEE (SEE REVERSE FOR PRIVACY INFORMATION)

09.17.02
 DATE SIGNED

PART G: AGENCY INFORMATION

15. AGENCY NAME	16. HEALTH BENEFITS OFFICER'S SIGNATURE
AGENCY CODE	PHONE ()
UNIT CODE	DATE RECEIVED

Nov 07 07 04:04p

Pier Spacio

818-832-6454

p. 1

(323) 771-0453

To: Lourdes Garcia

Re: Health benefit change

Please let me know if more information
is needed to change benefit from
PERS choice to PERS Care.

Thank you.

Ingeia

Dec. 13 07 10:54a

Pier Spaccia

818-832-6454

P.2



Office of Employer and Member Health Services
 P.O. Box 942714
 Sacramento, CA 94228-2714
 (888) CalPERS (225-7377)
 TDD - (916) 795-3240
 FAX (916) 795-1277

MEDICAL REPORT for the CalPERS DISABLED DEPENDENT BENEFIT

COMPLETE ALL ITEMS. INCOMPLETE FORMS WILL BE RETURNED CAUSING DELAY IN BENEFITS.

MEMBER PART A: THE MEMBER IS TO COMPLETE THE INFORMATION IN PART A:		DEPENDENT INFORMATION	
MEMBER INFORMATION		NAME: <u>Frank Thomas Spaccia - Sr. Field</u>	
NAME: <u>Pier Spaccia Sr</u>		SSN: <u>[REDACTED]</u>	
SOCIAL SECURITY NUMBER (SSN)		ADDRESS: <u>[REDACTED]</u>	
ADDRESS		DATE OF BIRTH: <u>01-15-1942</u>	
TELEPHONE: <u>[REDACTED]</u>			

PART B: DEPENDENT AUTHORIZATION: The dependent, or person authorized to act in his or her behalf, is to complete the information requested in PART B prior to giving the form to the physician for completion:

I hereby authorize my attending physician Dr. Wilazy C. Lellat to furnish and disclose all facts concerning my disability that are within his or her knowledge and to allow inspection, and provide copies, of any medical records concerning my disability that are under his or her control. This authorization shall be valid for a period of one year from the date of my signature or the effective date of this claim, whichever is later. I agree that a photocopy of this authorization shall be as valid as an original. I understand that if I do not sign this authorization, or if I revoke or modify it, CalPERS may not be able to determine my eligibility as a disabled dependent and that my request may be denied. I also understand that CalPERS will keep confidential the information which is provided pursuant to this authorization, and that it will be used solely to determine and act upon my request for this benefit.

Signature of Dependent OR
Frank Thomas Spaccia Sr
 Person authorized to act on his/her behalf

Date Signed
12/13/07
 Relationship to the dependent

PHYSICIAN PART C: The physician is to complete all requested information in PARTS C and D. All responses must be legible. Mail this completed form to CalPERS at the address found at the top of this page. Please DO NOT send information copied directly from the patient's medical record at this time.

Dear Doctor:
 The patient requests you to complete this Medical Report form. It will assist CalPERS in processing his or her claim for health insurance as a disabled dependent under his or her parent's or guardian's health plan. By providing the medical information promptly, you will help the patient expedite the claims process.

Medical Report	
1.	I attended the patient for the current disabling medical problem or condition from <u>01/15/07 to 12/13/07</u> At intervals of <u> </u> I last examined the patient on <u>12/13/07</u>
2.	Medical History (related to disability): Date of Disability Onset: <u>01/15/07</u>
3.	Diagnosis (REQUIRED): ICD-9 Disease Code, Primary (Required): <u>81.130</u> ICD-9 Disease Code(s), Secondary: <u>851.90</u> DSM IV Code(s) (if any): <u> </u>
4.	Objective Clinical Findings/Detailed Statement of Symptoms: (see page 2, Items 6 and 7 for additional findings)
5.	Current Treatment(s) and/or Medication(s) rendered to the patient for this disability: <input type="checkbox"/> The patient is not currently receiving treatment(s) and/or medications for this disability. (Check if applicable.)

(See page 2 of this for additional required information.)

Dec 13 07 10:55a

Pier Spaccia

818-832-6454

p. 3

MEMBER: Pier Spaccia
SSN: _____

DEPENDENT NAME: Sec: Thomas F. Spacia
SSN: _____

Medical Report	
6	<p>Functional Assessment of Activities of Daily Living (ADLs): Indicate the patient's degree of physical or mental disability in the following ADLs using a scale of 1 to 10. One (1) indicates the ADL is not affected by the patient's disability. A ten (10) indicates the patient is completely disabled in this ADL skill or ability. These functional disabilities limit the patient's capacity for self support.</p> <p>Mobility Skills Self-Care Skills Sensory Skills Cognitive Skills</p>
7	<p>Psychological / Psychiatric Assessment: List the specific psychological / psychiatric symptoms or behaviors, if any, that affect the patient's ADLs and limit his or her capacity to be self-supporting:</p>

PART D: Medical Certification of Disability and Incapacity of Self Support: For purposes of this benefit, a CalPERS member can retain his or her eligibility for health benefits as a family member if he or she is unmarried and incapable of self-support (i.e., not capable of engaging in any substantial gainful activity) due to physical or mental disability which existed continuously prior to becoming 23 years of age.

- Based upon your examination, does the patient currently have a physically or mentally disabling injury, illness or condition?
 NO, the patient does NOT have a physically or mentally disabling injury, illness or condition.
 YES (Please answer Question 2.)
- In your medical or psychiatric opinion, please select A, B, or C:
 A. The patient's current disability DOES NOT render him or her incapable of self-support.
 B. The patient's current disability DOES render him or her incapable of self-support, but the disability should resolve or improve sufficiently for the patient to be capable of self-support by 01/09
(projected DATE-mm/yy)
If the condition is likely to improve or resolve, make SOME "estimate" of when this will occur. Please DO NOT leave the DATE blank. Answers such as "indefinite" or "don't know" will not suffice.
 C. The patient's current disability is of a permanent or extended duration and, consequently, the patient is not and will not be capable of self support within the foreseeable future (e.g., more than 5 years).

I certify that, based upon my examination of the patient, the above statements truly describe the patient's disability and his or her capability of self support, and that I am a Surgeon General / Vascular
(Type of Physician) (Specialty, if any)

licensed to practice by the State of CALIFORNIA

PRINT, TYPE or STAMP PHYSICIAN'S NAME AS SHOWN ON LICENSE and HIS OR HER ADDRESS, TELEPHONE AND FAX NUMBERS.

Stéphane Chollet, M.D.
 PHYSICIAN'S NAME AS SHOWN ON LICENSE
12400 Ventura Blvd #374
 LOCAL ADDRESS
Studio City, CA
 CITY STATE
12/12/07
 DATE

Dr. Stéphane Chollet M.D.
 ORIGINAL SIGNATURE OF ATTENDING PHYSICIAN
A44834
 STATE LICENSE NUMBER
(213) 259-0602
 TELEPHONE NUMBER

 FAX NUMBER

PART E: CalPERS USE ONLY:

____ Claim approved for enrollment through _____ DATE (for next review)
 ____ Claim rejected.

____ REVIEWED BY _____
 _____ DATE

Dec 13 07 10:54a

Pier Spaccia

818-892-6454

p. 1

323 771-9473 fax

FOR: Lourdes Garcia

3 pages (including this page)

Thank You

Angel

SUMMARY STATEMENT

Blue Cross of California and
 BC Life & Health Insurance Company
 are Independent Licensees of the Blue Cross Association
 a Registered Mark of the Blue Cross Association

Subscriber Name : SEAN-THOMAS F SPACCIA-SHEFFIE Invoice No. : 033740303I
 Billing Entity No. : KB090F Page No. : 1

If you have any questions about this bill, please call (818) 234-8401

Billing Period : FROM 05-01-08 TO 06-01-08
 Date Billed : 04-27-08
 Payment Due Date : 05-01-08

Product Summary Information

Group No.	Product Name	No Cvd	Bill From	Bill To	Premium Amount
KB090F	PRUDENT BUYER INCENTIVE	1	05-01-08	06-01-08	711.83
Subtotal Current Charges					711.83
Prior Balance Due					279.76-
Retro Elig Adjs. Subtotal					0.00
Manual Adjustment					0.00
Total Amount Due					\$ 432.07

Please Return this Portion if Requesting Membership Changes

I authorize the following membership changes to my records, effective _____.

All Products: Yes or No _____ If No, Please specify Products: _____

Change _____ Add Member _____ Cancel Member _____ Reason: _____

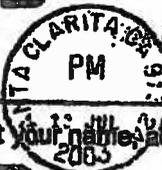
Last Name _____ First Name _____ Mi _____ DOB _____ Relationship _____

Address: _____
 Street _____ City _____ State _____ Zip _____

Signature _____ Date _____ Telephone Number (_____) _____

SENDER: COMPLETE THIS SECTION:	COMPLETE THE SECTION ON DELIVERY:	
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>x Pier' Angela Spaccia</i></p> <p>B. Received by (Printed Name) <input type="checkbox"/> Agent <input checked="" type="checkbox"/> Addressee <i>Pier' Angela Spaccia</i></p> <p>C. Date of Delivery <i>7-2-01</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, enter delivery address below:</p>	
<p>1. Article Addressed to:</p> <p><i>PIER' ANGELA SPACCIA</i></p> <div style="background-color: black; width: 150px; height: 20px; margin-top: 5px;"></div>	<p>3. Service Type</p> <p><input checked="" type="checkbox"/> Certified Mail <input type="checkbox"/> Express Mail</p> <p><input type="checkbox"/> Registered <input checked="" type="checkbox"/> Return Receipt for Merchandise</p> <p><input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p>	
<p>2. Article Number (Transfer from service label)</p> <p><i>7000 1670 0013 0727 4629</i></p>	<p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>	
<p>PS Form 3811, August 2001 Domestic Return Receipt 102585-02-11-154</p>		

UNITED STATES POSTAL SERVICE



First-Class Mail
 Postage & Fees Paid
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 Permit No. 6-10

• Sender: Please print your name, address, and ZIP+4 in this box.

Theresa Diaz
 City of Bell
 6380 Pine AVENUE
 BELL CA 90201

27





6330 Pine Avenue
Bell, CA 90201 - 1291
(323) 588 - 6211
Fax: (323) 771 - 9473

Tuesday, July 08, 2003

Pier' Angela Spaccia
[REDACTED]

Dear Ms. Spaccia & Dependents:

City of Bell allows continued medical, dental and vision benefits for you and your covered dependents, under certain circumstances because of a federal law -- the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It is important that you are aware of this plan provision, since you will be required to take specific actions to exercise your rights to continued coverage. Please review the following information carefully and save it for future reference.

When Does the Continuation Provision Apply?

The continuation provision applies when you, your spouse or a covered dependent (called a "qualified beneficiary") experience a situation (called a "qualifying event") which would normally result in your loss of coverage under the City of Bell Benefits Plan.

As an employee of City of Bell covered by the City of Bell Benefits Plan, you have a right to choose Continuation Coverage if:

- (1) You lose your group health coverage because of a reduction in your hours of employment, or
- (2) the termination of your employment (for reasons other than gross misconduct on your part).

As the spouse of an employee covered by the City of Bell Benefits Plan, you have the right to choose continuation coverage if you lose group health coverage under the City of Bell Benefit Plans for any of the following reasons:

- (1) The death of your spouse;
- (2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
- (3) Divorce or legal separation from your spouse; or
- (4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by the City of Bell Benefit Plans, he or she has the right to continuation coverage if group health coverage under the City of Bell Benefit Plans is lost for any of the following reasons:

- (1) The death of a parent (employed by City of Bell);
- (2) The termination of a parent's employment (for reasons other than gross misconduct) or reduction in parent's hours of employment with City of Bell;
- (3) Parents' divorce or legal separation;
- (4) A parent becomes entitled to Medicare; or
- (5) The dependent ceases to be an "eligible dependent child" under the City of Bell Benefit Plans.

How Much Does Continued Coverage Cost?

You are required to pay the full cost of continued coverage plus a 2% charge to cover the cost of plan administration. You will be asked to pay for the coverage in monthly installments and your first payment must begin no later than 45 days after the date that you elect continued coverage. The Finance Department can provide you with current cost information.

If health care continuation is extended to individuals who are deemed disabled by the Social Security Administration, employers are permitted to charge 150 percent of the applicable premium for up to 11 additional months of coverage provided to disabled beneficiaries.

Can I Continue Full Health Coverage?

If you choose continued coverage, you will have coverage which -- at the time the coverage is being provided -- is identical to that provided under the plan to similarly situated employees or dependents who have not experienced one of the above qualifying events. You will be entitled to the same coverage you had on the day prior to your qualifying event, and both you and your dependents cannot be asked to furnish evidence of insurability. During the time you and your dependents are covered by COBRA continuation, you will be entitled to the same coverage options that are available to active employees, including, for example, the right to change coverage at open enrollment and the right to modify coverage in the event of a change in your coverage needs. You will be notified of these options at the same time as the active employees by mail to your last known address. If you do not choose continued coverage, your group health coverage will end on the last day of the month in which the qualifying event occurred.

How Long is COBRA Period of Coverage?

In general, coverage may be continued for 18 months after the date of the qualifying event -- in the case of termination of employment or reduction of hours -- and for 36 months for all other events listed on the previous page. Since your medical plan provides you with the option to convert to individual coverage, you can exercise that option during the last 180 days of continued coverage.

You may choose not to convert your medical plan to individual conversion coverage. In this case, you may purchase an individual medical policy from any carrier selling these types of policies statewide. These carriers must sell you their two best selling individual medical policies. You must exhaust your COBRA continuation in order to be eligible to purchase an individual policy (as allowed under HIPAA).

COBRA coverage may now continue until a qualified beneficiary becomes covered under any other group health plan, which does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. In other words, a beneficiary who becomes covered under a group health plan with a pre-existing conditions clause must be allowed to retain COBRA coverage.

Health care continuation coverage is extended from 18 to a maximum of 29 months for individuals (and all related qualified beneficiaries) who were disabled (in accordance with Titles II or XVI of the Social Security Act) at the time of the initial qualifying event or during the first 60 days of COBRA coverage. The purpose of this change is to allow disabled persons and their covered qualified dependents to continue their group medical benefits during the 29-month waiting period for Medicare medical benefits. In order to obtain the 11-month extension, you must notify City of Bell of the Social Security determination of disability within 60 days of the date the determination is made and before the end of the original 18 months of COBRA Continuation Coverage.

Coverage could be terminated earlier than the above dates if:

- (1) the qualified beneficiary first becomes covered, after the date of the qualifying event, under another group health plan (which does not restrict coverage for your pre-existing condition/if any);
- (2) the qualified beneficiary first becomes entitled, after the date of the qualifying event, to Medicare;
- (3) the qualified beneficiary fails to make a required premium payment;
- (4) City of Bell terminates all of its group health plans;
- (5) the disabled, qualified beneficiary is no longer disabled after the first 18 months on continuation coverage.

You must notify Angela Santana upon the occurrence of events (1) and (2) above.

What Must I Do To Obtain Continued Coverage?

You have the responsibility of notifying City of Bell Benefits Plan when certain events occur which qualify you for continued coverage:

You or your covered dependent(s) must notify the City of Bell within 60 days in the event of:

- Divorce or legal separation
- Cessation of dependent child coverage.

The Finance Department will notify you or your covered dependents of your right to elect continued coverage within 14 days in the event of:

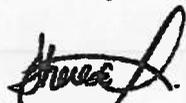
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- Reduction in hours
- Employee's death
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You or your covered dependents will have a 60-day election period during which continued coverage may be elected. The period begins the later of (1) the date your coverage terminates by reason of the qualifying event or (2) the date you or your covered dependents were notified of your right to elect continued coverage.

Additional Information

If you have any questions or need further information about the continued coverage provision, please contact me at (323) 588-6211, extension 217. Also, if you have changed marital status, or if you or your spouse have changed your address, please notify City of Bell at the above address.

Sincerely,



Theresa Diaz
Management Analyst

Cc: Personnel File



6330 Pine Avenue
Bell, California 90201-1291

CERTIFIED MAIL



7000 1670 0013 0727 4629

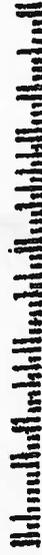


NAME *PA*
1st Police
2nd Police
Return

Pier' Angela Spaccia



91326-2323 03



U.S. POSTAL SERVICE
CERTIFIED MAIL RECEIPT
(Domestic Mail Only - No Insurance Coverage Provided)

OFFICIAL USE

Postage	\$	Postmark "63 Here
Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		
Total Postage & Fees	\$	

7000 1670 0013 0727 4629

Sent To
Street, Apt. No.; or PO Box No.
City, State, ZIP+4



6330 Pine Avenue
Bell, CA 90201 - 1291
(323) 588 - 6211
Fax: (323) 771 - 9473

Tuesday, July 08, 2003

Pier Angela Spaccia

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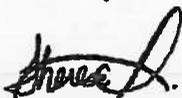
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Additional Information

If you have any questions or need further information about the continued coverage provision, please contact me at (323) 588-6211, extension 217. Also, if you have changed marital status, or if you or your spouse have changed your address, please notify City of Bell at the above address.

Sincerely,



Theresa Diaz
Management Analyst

Cc: Personnel File

"Precautionary"



Disability Retirement Election Application

888 CalPERS (or 888-225-7377) • TTY for Speech and Hearing Impaired: (916) 795-3240

Employer Information

Check if this is an employer-originated application.

Employer must fill out and sign Section 12 on the last page of this application.

Application Type

Disability Retirement

Industrial Disability Retirement

Service Pending Disability Retirement

Service Pending Industrial Disability Retirement

Section 1

Please provide your name as it appears on the Social Security card.

Information About You

Pier Anaela SPACCIA
Name of Member (First Name, Middle Initial, Last Name)

Address

City

09/19/1958
Birthdate (mm/dd/yyyy)

Male Female
Gender

Display all dates in this order: month/day/year.

Section 2

Please do not abbreviate your employer or position.

Do not list Social Security, military or railroad retirement as a California public retirement system.

Retirement Information

Retirement Date (mm/dd/yyyy)

City of Bell
Employer

Assistant Chief Administrative Officer
Position Title

Do you have any final compensation period higher than the last consecutive 12 or 36 months?

No Yes, from Beginning Date (mm/dd/yyyy) to Ending Date (mm/dd/yyyy)

Are you a member of a California public retirement system other than CalPERS? No Yes, provide:

Name of System

Date of Retirement (mm/dd/yyyy)

Beginning Service Credit Date (mm/dd/yyyy)

Ending Service Credit Date (mm/dd/yyyy)

Section 3

Local safety members should not complete Sections 3 & 4.

Workers' Compensation Information

Workers' Compensation Carrier

Name of Adjuster

Phone Number

Address

City

State

ZIP

Claim Number(s) Relating to Alleged Disability

Date of Injury (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Per Angela SPACCIA
Your Name

[Redacted]
Social Security Number

Section 4

Disability Information

Please complete all the questions below. If you need additional space, attach separate sheets and be sure to include your name and Social Security number on all sheets.

What is your specific disability; when and how did it occur?

What is the complete name and address of your treating physician(s)?

Name of Treating Physician Medical Record Number

Address

City State ZIP Phone Number

What are your limitations/preclusions due to your injury or illness?

How has your injury or illness affected your ability to perform your job?

Are you currently working in any capacity (full-time, part-time, or modified work)? If yes, please explain.

Other information you would like to provide.

Did a third party cause your injury? No Yes (If yes, CalPERS has a potential "right of subrogation.")

Put your name and Social Security number at the top of every page.

Pier Angela Spaccia
Your Name

[Redacted]
Social Security Number

Section 5

Select Your Retirement Payment Option and Beneficiary

Select only one payment option: Option 1, Option 2, Option 2W, Option 3, Option 3W, the Unmodified Allowance Option, or one of the Option 4 types.

By filling out this section, you are electing your Retirement Payment Option and designating your beneficiary. Once you select a payment option, you cannot change to another option. Along with your option selection, you must complete at least one of the beneficiary designations in Sections 5a-5d. If you choose the Unmodified Allowance Option, you do not need to specify a beneficiary. Please see pages 18 to 22 for more information on this section.

- Option 1 - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
- Option 2 - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- Option 2W - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- Option 3 - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- Option 3W - To complete this option choice, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
- Unmodified Allowance Option - If you select this option there is no return of your member contributions and no monthly benefits payable upon your death - except the Survivor Continuance benefit, if applicable. There is no beneficiary designation for this option.

These options apply to Option 4 Individual Lifetime Beneficiary only.

- Option 4, Individual Lifetime Beneficiary - If you select this option, you must also select one of the following Individual Lifetime Beneficiary options below.
 - Option 2W & Option 1 Combined - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
 - Option 3W & Option 1 Combined - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary* and Section 5d *Balance of Contributions Beneficiary(ies)*.
 - Specific Dollar Amount to Beneficiary \$ _____ Dollars - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*.
 - Specific Percentage to Beneficiary _____ % - To complete this option choice, you must also fill out Section 5a *Individual Lifetime Beneficiary*.
 - Reduced Allowance for Fixed Period of Time _____ through _____
Percentage or Dollars Date (mm/yyyy)
 - Reduced Allowance upon death of retiree or beneficiary: \$ _____ reduction amount
Dollars
If you are naming a beneficiary under this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

This option applies to Option 4 Multiple Lifetime Beneficiaries only.

- Option 4, Multiple Lifetime Beneficiaries - To complete this option choice, you must also fill out Section 5b *Option 4 Multiple Lifetime Beneficiaries*.

These options apply to Option 4, Court Ordered Community Property only.

- Option 4, Court Ordered Community Property - If you select this option, you must also complete Section 5c, *Court Ordered C.P. Beneficiary* and select one of the following Court Ordered Option 4 Community Property options.
 - Option 4/Unmodified - There is no additional beneficiary designation for this option.
 - Option 4/1 - To complete this option choice, you must also fill out Section 5d, *Balance of Contributions Beneficiary(ies)*.
 - Option 4/2W - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.
 - Option 4/3W - To complete this option, you must also fill out Section 5a, *Individual Lifetime Beneficiary*.

Put your name and Social Security number at the top of every page.

Pre' Angela Spaccia [Redacted]
Your Name Social Security Number

Section 5

Option 1 Balance of Contributions Beneficiary(ies)

Designate up to three beneficiaries here. If you want to designate more than three beneficiaries. See page 23 for information on completing the Lump Sum Beneficiary Designation form.

Complete this section only if you selected Option 1, Option 4-2W/1 or 3W/1 combined. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to pages 23 and 24 of this booklet.

Name (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Relationship to You
Address
City State ZIP Country

Name (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Relationship to You
Address
City State ZIP Country

Name (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Relationship to You
Address
City State ZIP Country

Section 6

Retired Death Benefit

All Applicants must complete this section.

This section designates the person who will receive your lump sum Retired Death Benefit. You may change this beneficiary(ies) at any time. This designation automatically revokes when there is a change in your marital status, domestic partnership status, or when there is a birth or adoption of a child. For detailed information and instructions please refer to page 24 of this booklet.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Sean Thomas F. Spaccia - Sheffield [Redacted]
Name (First Name, Middle Initial, Last Name) Social Security Number

01/15/1983 Male Female 1 Son
Birthdate (mm/dd/yyyy) Gender Relationship to You

[Redacted]
Address
City

Section 6 continues on page 6

Put your name and Social Security number at the top of every page.

Ree'Angela Spaccia [Redacted]
Your Name Social Security Number

Section 6, continued

Retired Death Benefit

All Applicants must complete this section.

Designate your beneficiary to receive your lump sum Retired Death Benefit.

Name (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Relationship to You
Address
City State ZIP Country
Name (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Relationship to You
Address
City State ZIP Country

Section 7

Survivor Continuance

Please answer all five questions and complete the information in each section where you answered "Yes."

Please see pages 24 and 25 for more information on this section.

1. Will you be married on, and at least one year prior to, your retirement date? [X] No [] Yes, provide:

Name of Spouse (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Date of Marriage

2. Will you be registered with the California Secretary of State as being in a domestic partnership on and at least one year prior to your retirement date? [X] No [] Yes, provide:

Name of Domestic Partner (First Name, Middle Initial, Last Name) Social Security Number
Birthdate (mm/dd/yyyy) Gender Date of Registered Partnership (mm/dd/yyyy)

3. Do you have any natural or adopted children under age 18 who have never been married? [X] No [] Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)
Name of Child (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)

4. Do you have any children who have never been married and were disabled prior to their 18th birthday and who are still disabled? [X] No [] Yes, provide:

Name of Child (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)
Name of Child (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)

5. Are your parents dependent upon you for one-half of their support? [X] No [] Yes, provide:

Name of Parent (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)
Name of Parent (First Name, Middle Initial, Last Name) Social Security Number Birthdate (mm/dd/yyyy)

Put your name and Social Security number at the top of every page.

Pier Angela Spacia
Your Name

[Redacted]
Social Security Number

Section 11

Member Signature and Notary

This section must be completed or your application will be returned.

I certify, under the penalty of perjury, that the information submitted hereon is true and correct to the best of my knowledge. I understand to cancel this application or to change the elected option or beneficiary I must notify CalPERS before the mailing of my first full monthly retirement allowance check.

If your spouse's or domestic partner's signature is not available, See instructions in this booklet on completing the Justification for Absence of Signature form. Your signature and your spouse's or domestic partner's signature must be notarized by a notary public or witnessed by a CalPERS representative.

I understand that if I am married or in a registered domestic partnership, but do not name my spouse or partner as beneficiary, they may still be entitled to a community property share of the Option 1 lump sum return of contributions benefit or a share of the monthly option death benefit allowance. Their community property interest is 50% of the benefit based on the contributions or service credit earned for the period of CalPERS service during which we were married or in a registered partnership. My non-spouse or non-partner designated beneficiary will receive the portion of the lump sum Option 1 benefit or monthly option allowance that is not payable to my spouse or domestic partner. I understand that my spouse or domestic partner will have the right to disclaim entitlement to their community property interest in the death benefit at the time the benefit becomes payable, if they so desire.

More detailed information on this section is available in this publication.

Are you legally married or do you have a legal domestic partner? Yes No

If yes, your spouse or domestic partner must sign this election.

If no, please indicate: Never Married/or in Partnership Divorced/Annulled Widowed Or Termination of Domestic Partnership

Pier Angela Spacia
Your Signature

Date (mm/dd/yyyy)

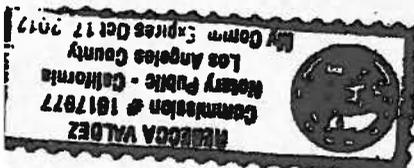
Your Spouse's or Domestic Partner's Signature

Date (mm/dd/yyyy)

State of California, County of LOS ANGELES

On _____ Date before me, REBECCA VALDEZ, NOTARY PUBLIC Name of Notary/Witness

personally appeared PIER ANGELA SPACIA, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I certify under Penalty of Perjury under the laws of the State of California that the foregoing paragraph is true and correct.



Notary Seal

Place my hand and official seal or authorized CalPERS representative signature.

Signature of Notary or CalPERS Representative

NOTARY PUBLIC
Position Title

Date (mm/dd/yyyy)

REBECCA VALDEZ
Print Name

CalPERS Office (if applicable)

Section 12

Employer-Originated Application

To be completed if the employer is submitting the application on behalf of the member.

Signature of Employer

Print Name of Employer

Position Title of Employer

Phone Number

Date (mm/dd/yyyy)

Mail to:

CalPERS Benefit Services Division • P.O. Box 942711, Sacramento, California 94229-2711

INFORMATION AND INSTRUCTIONS FOR CALPERS BENEFICIARY DESIGNATION FORM

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please see your personnel offices for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally injured while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for at least one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

If you *do* have a valid beneficiary designation on file, your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-domestic partner designated beneficiaries will receive the portion of your lump sum benefits which are not payable to your spouse/registered domestic partner as his/her community property share.

C. If A. and B. do not apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none;
2. Natural and adopted children, including (in limited situations) a natural child adopted by another share and share alike, or, if none;
3. Parents, share and share alike, or, if none;
4. Brothers and sisters, share and share alike, or, if none;
5. Your estate (if probated, or subject to probate), or, if none;
6. Your trust (if one exists) or, if not;
7. Stepchildren, share and share alike, or, if none;
8. Grandchildren, including step-grandchildren, share and share alike, or, if none;
9. Nieces and nephews, share and share alike, or, if none;
10. Great grandchildren, share and share alike, or, if none;
11. Cousins, share and share alike.

If A. and B. do not apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. However, if you are married or have a registered domestic partner at the time of death, your spouse/domestic partner may still be entitled to a community property share of your lump sum contributions.

D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation Form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: If you are married or in a domestic partnership at the time of your death and you do not name your spouse/domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a monthly death benefit allowance, if applicable.

E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CALPERS:

1. Marriage/Registration of Domestic Partnership;
2. Dissolution or annulment of your marriage or dissolution of your domestic partnership. However, a designation filed after the initiation of dissolution/annulment of marriage or dissolution of domestic partnership is NOT revoked when the dissolution/annulment is finalized, or;
3. Birth or adoption of a child; or
4. Termination of membership that results in a refund of your contributions.

INSTRUCTIONS

1. Print clearly with ballpoint pen or type all information requested. If you make an error, make the necessary correction by lining through the error and initialing the change. No erasures or correction fluid will be accepted.
2. Enter on the form the full name of your beneficiary, relationship, social security number (if known), and the complete address for each. (If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating primary or secondary beneficiaries. You must sign, date, and write your social security number at the top of each additional sheet.)
3. If a (%) is entered, make sure the total equals 100%.
4. Your spouse/registered domestic partner must sign the form to acknowledge the names of the beneficiaries you are designating. **IMPORTANT:** If you are unable to obtain your spouse's/domestic partner's signature, you **MUST** complete the BSD-800, "Justification for Absence of Spouse or Domestic Partner's Signature" form, on the reverse side of the designation form or your designation form may be rejected.
5. Enter the date you signed the form and your current mailing address.
6. Mail the completed form to the Public Employees' Retirement System at the address shown, or you may fax it to (916) 795-3933.
7. After CalPERS receives and reviews the form a confirmation letter will be mailed to you within 6 weeks. If the form is not acceptable a new form will be mailed to you to complete.

IMPORTANT INFORMATION

The Information Practices Act of 1977 and the Federal Privacy Act require the California Public Employees' Retirement System to provide the following information to individuals who are asked to supply information. The information requested is collected pursuant to the Government Code Sections 20000, et seq. and will be used for administration of the System (including under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Expense Act) as the customer. Failure to supply all of the requested information may result in the System being unable to perform its functions regarding your status. Portions of this information may be transmitted to state and public agency employers, California State Attorney General's Office, State Controller, State Board of Equalization, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfilm for the CalPERS. Sections to these parties include information regarding your contributions.

You have the right to review your membership file maintained by the California Public Employees' Retirement System. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Practices Act Coordinator, CalPERS, P.O. Box 942701, Sacramento, CA 95821.



Benefit Services Division
P.O. Box 942761
Sacramento, CA 95229-2711
(888) Cal-PERS (225-7377)
TDD: (916) 795-3240; FAX: (916) 795-3993

JUSTIFICATION FOR ABSENCE OF SPOUSE OR REGISTERED DOMESTIC PARTNER'S SIGNATURE

Pursuant to Government Code Section 21261, the member's current spouse or registered domestic partner must be made aware of the selection of benefits or change in beneficiary made by the member. The spouse or domestic partner of a CalPERS member must acknowledge the submission of a request for refund of contributions; election of retirement optional settlement; and designation of beneficiary for Pre-retirement Death Benefits.

If a spouse or domestic partner's signature does not appear on one of the above mentioned documents, the following information **MUST** be completed by the member and submitted with the application form.

MEMBER'S NAME (TYPED OR PRINTED)	SOCIAL SECURITY NUMBER
APPLICATION SUBMITTED:	
BENEFICIARY DESIGNATION PERD 850-317	

Select either 1 or 2 and indicate specifics.

- By checking this box, I indicate that I am not legally married or in a registered domestic partnership because:
 - Never married or never in registered domestic partnership.
 - Divorced / marriage annulled or domestic partnership terminated. Date: (mm/dd/yyyy)
 - Widowed. Date: (mm/dd/yyyy)
- By checking this box, I indicate that I am married or have a domestic partner, but my spouse or domestic partner did not sign this form because:
 - I do not know and have taken all reasonable steps to determine either who made the above-mentioned application or domestic partner. OR;
 - My spouse or domestic partner has been advised of the application and has refused to sign the written acknowledgement. OR;
 - My spouse or domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition. OR;
 - My spouse or domestic partner has no identifiable community property interest in the benefit. OR;
 - My spouse or domestic partner and I have executed a marriage settlement or partitioning agreement that makes the community property laws inapplicable to the marriage or partnership.

Especially, indicate penalty of perjury that the foregoing is true and correct.

MEMBER'S SIGNATURE	DATE SIGNED
--------------------	-------------

071 221 2000 22.02 2120240900

312 RESIDENTIAL ALU10

PAGE 02

Standard Insurance Company

Enrollment and Change Form

Check all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle) Spaccia, Pier' Angela		Group Name	Group Number(s)
	City		Date of Birth 9-19-58	Sex Male <input type="radio"/> Female <input checked="" type="radio"/>
		Job Title/Occupation Asst. CAD		

Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

1. Life Insurance
 Life Life with AD&D Employer paid amount \$ _____
 Additional/Optional Life Additional/Optional Life with AD&D Your requested amount \$ _____

2. Voluntary Life Insurance
 Voluntary Life Voluntary Life with AD&D Your requested amount \$ _____

3. Dependents Life Insurance
 Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____
 Children requested amount \$ _____

4. Accidental Death and Dismemberment (AD&D) Insurance
 AD&D Employer paid amount \$ _____ Voluntary AD&D Your requested amount \$ _____

5. Supplemental Life Insurance Your requested amount \$ _____ Spouse requested amount \$ _____

6. Short Term Disability Employer Paid Enhanced (Buy-up) Voluntary STD

7. Long Term Disability Employer Paid Enhanced (Buy-up) Voluntary LTD

8. Dental (See below) Employer Paid High Plan Voluntary Dental

Marital Status Single Married **Divorced**

Coverage requested for You, your spouse and children You and your spouse You only **You and your children (no spouse)**

Are you covered for dental insurance under another plan? **Yes** No Are one or more dependents? **Yes** No

List dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex		Date of Birth	List dependents to enroll or delete. (Attach sheet for additional dependents if needed.)	Sex		Date of Birth
	M	F			M	F	
Spouse				Child 2			
Child 1 Sean Thomas Frances CO	X		1-15-83	Child 3			

Dental Insurance Waiver: Contributory Dental Insurance
 The Dental Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Dental Insurance coverage may be subject to a Late Enrollment Penalty.
 I decline Dental Insurance for myself I decline Dental Insurance for one or more Dependents

This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 2 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Sections 4 and 5 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Sean Thomas Francesco Spaccia	Sheffield		Son	100%
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Pier' Francesco CO Spaccia			Brother	50
Marcus Aurelius Spaccia			Brother	50

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

Add Dependent Delete Dependent Name Change **Beneficiary Change**

Date of add/delete _____ Former name _____ Other _____

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required **Pier' Angela Spaccia** Date (Mo/Day/Yr) **8-27-08**

Human Resources Department - Complete this section. Retain form for your records.

Division ID	Billing Category	Date of Hire or Rehire	Hours Worked Per Week	Earnings \$ _____	Per: Hour Wk Mo Yr
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Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.



CITY OF BELL

DESIGNATION OF BENEFICIARY

Any person now or hereafter employed by the City of Bell may file with his appointing power a designation of a person who, notwithstanding any other provision of the law, will receive all warrants or checks that would have been payable to the decedent had he survived. A person designated shall claim such warrants or checks from the appointing power.

On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check is entitled to negotiate it as if he were the payee.

You are entitled to change the designation, as you deem necessary. This person may be designated by you filling in the following:

To the appointed authority:

I, Pier'Angela Spaccia Do hereby designate
Sean Thomas F. Spaccia-Stafford to receive all warrants or checks at the time of
my death, due me by the City of Bell.

Pier'Angela Spaccia
Signature

8-27-08
Date

In the event of my death prior to retirement, please FAX a copy of this document to PERS for handling.

Prior to submitting the fax:

- Becky Valdez will need to date her notarization, effective the date it is being sent in.
- Section 9 – Employer Certification must be completed.

Call one of the following people to get the appropriate fax number to submit this to PERS.

Donna Hagel (916) 795-3359

Julie Watson (916) 795-3217

Liz Burke (916) 795-3120

Thank you!

Angel Garcia

**EMPLOYEE DATA
INFORMATION**

**Birth/Marriage
Certificates**

Designation of Beneficiary



TO: CALPERS/ Benefit Services Division
 P.O. Box 942711
 Sacramento, CA 94229-2711
 Fax: (916) 795-3933
 Phone: (888) CalPERS (226-7377)

MEMBER'S FULL NAME (PLEASE PRINT) <i>Fier Angela Spaccia</i>	SOCIAL SECURITY NUMBER	BIRTH DATE <i>9-19-58</i>	TELEPHONE NUMBER
---	------------------------	------------------------------	------------------

I understand that if I am married or in a registered domestic partnership but do not name my spouse or domestic partner as beneficiary, she/he may still be entitled to a community property share of my 'Lump Sum Contributions' or a share of any monthly allowance that may be payable. My 'Non-Spouse or Non-Partner' designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid SHARE AND SHARE ALIKE.

PRIMARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
<i>Sean Thomas</i>	<i>F.</i>	<i>Spaccia</i>	<i>100</i>	<i>Son</i>	
ADDRESS (Number and Street) (City) (State) (Zip Code)					

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid SHARE AND SHARE ALIKE.

SECONDARY BENEFICIARIES

FIRST NAME	MIDDLE NAME	LAST NAME	%	RELATIONSHIP TO MEMBER	SOCIAL SECURITY NUMBER
<i>Angela</i>	<i>Michelle</i>	<i>SPACCIA</i>	<i>100</i>	<i>Niece</i>	
ADDRESS (Number and Street) (City) (State) (Zip Code)					

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

BY THIS BENEFICIARY DESIGNATION, I HEREBY REVOKE ANY PREVIOUS DESIGNATION I HAVE FILED. I UNDERSTAND THAT MY MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP, DISSOLUTION OR ANNULMENT OF MY MARRIAGE OR DOMESTIC PARTNERSHIP, OR THE BIRTH OR ADOPTION OF A CHILD OR TERMINATION OF MEMBERSHIP SUBSEQUENT TO THE DATE I FILE THIS FORM WITH CALPERS, WILL AUTOMATICALLY VOID THIS DESIGNATION. HOWEVER, A DESIGNATION FILED AFTER THE INITIATION OF A DISSOLUTION/ANNULMENT OF MARRIAGE OR REGISTERED DOMESTIC PARTNERSHIP IS NOT REVOKED WHEN THE DISSOLUTION/ANNULMENT IS FINALIZED.

Signatures Required

Are you legally married or have a registered domestic partner? No Yes
 If yes, your spouse or registered domestic partner must sign this form
 If no, please indicate: Never married/for Never in Domestic Partnership Divorced/Annulled Widowed

IMPORTANT - You must complete the BSD-900 on the reverse side of this form if you are married or have a registered domestic partnership but your spouse or domestic partner is unable to sign below.

MEMBER SIGNATURE: *Fier Angela Spaccia* Date: *11/13/06*

MEMBER ADDRESS: _____

SPOUSAL/REGISTERED DOMESTIC PARTNER ACKNOWLEDGEMENT: By signing this beneficiary designation form, I acknowledge the information entered by my spouse/domestic partner.

SPOUSE/DOMESTIC PARTNER SIGNATURE: _____

Standard Insurance Company

Enrollment and Change Form

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

Enrollment		Change			
<input checked="" type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Delete Dependent	<input type="checkbox"/> Date of add/delete		
<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change <input type="checkbox"/> Other		
Group Name		Group Number		Division ID	
City of Bell		643024			
Your Name (Last, First, Middle)		If Name Change, What Was Your Former Name?		Soc. Sec. No.	
SPACCIA, Pier Angela					

Date Of Birth	<input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Earnings \$ 130,000	Per. <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input checked="" type="checkbox"/> Yr
9/19/58			
Date Of Hire	Hours Worked Per Week	Job Title/Occupation	
7/1/03	40+	Assistant to the CAO	

Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.

1. Life Insurance

 Life/AD&D

This designation applies to Coverage Section 1 coverage above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Sean Thomas F. Spaccia			500	100
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Angela Michelle Spaccia	11	DOB 1/25/89	niece	100

I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member Signature Required	Date (Mo/Day/Yr)
Pier Angela Spaccia	11/19/04

Human Resources Department - Retain for your records.

**Personnel Information
Change of Address**

City of Bell

Memorandum

DATE: January 23, 2004

TO: Theresa Diaz and Alex Veloz

FROM: Angela Spaccia

SUBJECT: Change of Address and Phone Number

Please change my personnel record and City phone contact lists to reflect my change of address and/or contact phone numbers.

The new address is:

The new phone numbers are: home-
Cell-

My work related cell phone number is still:

*Recall
Ass
Green Card* #148

Miscellaneous

**POLICY ACKNOWLEDGMENT AND OATH
CODE OF ETHICS AND VALUES POLICY**

Oath

I have read the City of Bell's Code of Ethics and Values policy and understand its expectations. I agree that compliance with all local, state and federal laws and regulations is an inherent quality of ethical behavior. Such laws govern, but are not limited to, disclosure of personal economic interests; receipt of loans, gifts, travel payments and honoraria; campaign contributions; conflict of interest; dual office-holding and incompatible offices; and criminal misconduct in office. Although compliance with all such laws is expected, I understand that this code applies exclusively to ethical values rather than legal issues. The ethics defined in this code require more than simple adherence to the law. By signing this code, I pledge my commitment to uphold a standard of integrity and competence beyond that required by the law.

I fully understand that I am subject to the City's commendation or censorship, depending upon my ability to exemplify the ethical behavior promoted by this code.

Angela S. [Signature]
Please Print Name

[Signature]
Signature

6/18/09
Date

**POLICY ACKNOWLEDGMENT AND OATH
MONEY AND GIFTS POLICY**

Oath

I have read the City of Bell's Money and Gift policy and understand its expectations. I agree that compliance with all local, state and federal laws and regulations is an inherent quality of ethical behavior. Such laws govern, but are not limited to, disclosure of personal economic interests; receipt of loans, gifts, travel payments and honoraria; campaign contributions; conflict of interest; dual office-holding and incompatible offices; and criminal misconduct in office. Although compliance with all such laws is expected, I understand that this policy applies exclusively to gifts and gratuities rather than legal issues. By signing this code, I pledge my commitment to uphold this policy.

I fully understand that I am subject to the City's commendation or censorship, depending upon my ability to adhere to the requirements stipulated in this policy.

Angela Spaccia
Please Print Name

Fred Spaccia
Signature

6/18/09
Date

**Original Pre-Employment
Documents**

Employee # 148

Full Time Employees

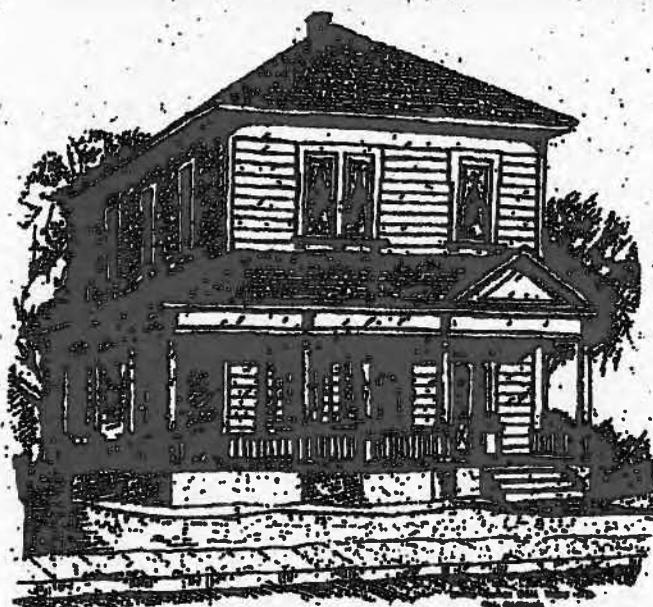
Name: Angela Spruca Date Hired: 10 30 2013

To be filled out by employee:

- PERSONAL INFORMATION Employee File
- OATH OF ALLEGIANCE (All Safety personnel must be sworn in by City Clerk) Employee File, City Clerk
- W-4, DE-4 Employee File
- I-9 Folder
- PRE-EMPLOYMENT RELEASE & WAIVER Employee File
- AUTHORIZATION TO RELEASE INFO Employee File
- DESIGNATION OF BENEFICIARY Employee File
- ACKNOWLEDGEMENT FORM Employee File
- DMV RELEASE OF INFORMATION Employee File
- EMPL NOTICE OF DESIGNATED PHYSICIAN Employee File
- EMPLOYEE RULES & REGULATIONS Employee File
- BILINGUAL PAY Employee File
- ACH DIRECT DEPOSIT Payroll

To be filled out by personnel:

- PERSONNEL ACTION FORM Employee, Employee File, Payroll & Dept.
- GRIEVANCE CARD Card File
- ~~FINGERPRINT CARD~~ Dennis Tavernelli (Ext. 252) Employee File
- ~~IDENTIFICATION CARD~~ Dennis Tavernelli (Ext. 252) Employee
- ~~BACKGROUND CHECK~~ Date _____ Dennis Tavernelli (Ext. 252) Employee File
- REPORT OF NEW EMPLOYEES Date _____ EDD
- ~~PHYSICAL EXAMINATION~~ Date _____ Folder
- Social Security Number Verification - Date _____ Social Security Administration
- AESD-1 7/2 HBD-12 9/2 HBD-12A 4/2 Employee File
- DELTA DENTAL 7/2 VISION 7/2 & CANADA LIFE 7/2/03 Employee File
- COBRA LETTER Date #1 Employee File



THE JAMES GEORGE BELL HOUSE

1999-2000 PROGRAM OF SERVICE

PERSONAL INFORMATIONDATE EMPLOYED 6/30/03 (MALE) (FEMALE) EEOC _____Name Spaccia Pier'Angela _____
Last First Middle Initial

Address _____

Telephone _____

Social Security No. _____ Birthday 9-19-58

Spouse's Name _____ Birthday _____

DEPENDENTS

NAME	AGE	RELATIONSHIP
<u>Sean</u>	<u>20</u>	<u>son</u>

EMERGENCY INFORMATIONName Spaccia-Sheffield Sean-Thomas Francesco _____
Last First Middle InitialRelationship sonAddress same

Telephone _____

I.D. CARD INFORMATION5'6" 135 Hazel Brown New York
Height Weight Eyes Hair Place of Birth

Driver's License No. _____

Blood Type _____

AKA's _____

Oath of Allegiance for Public Officers and Employees

(Required by Article 20, Section 3, California Constitution and Chapter 8,
Division 4, Title 1 of Government Code)

I, Pier Angela Spaccia, do solemnly swear that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies, foreign and domestic; that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties upon which I am about to enter.

Subscribed and sworn to before me this 30 day of June
2003.

Pier Angela Spaccia
Signature of Person Taking Oath

The above oath was taken and
subscribed to before me this
1 day of July 2003

[Signature]
Deputy City Clerk



6330 Pine Avenue
 Bell, CA 90201 - 1291
 (323) 588 - 6211
 Fax: (323) 771 - 9473

AUTHORIZATION TO RELEASE INFORMATION

As an applicant for a position with the City of Bell, I am required to furnish information for use in determining my qualifications. In this connection, I authorize release of any and all information that you may have concerning me. This authorization includes, but is not limited to, my work record, school record, reputation, financial and credit status; including information of a confidential or privileged nature which does include any disciplinary action.

I hereby release you, your organization or others for liability of damage, which may result from furnishing the information, requested. This release will expire 180 calendar days after the date signed.

SIGNED: Pier'Angela Spaccia Pier'Angela Spaccia

DATE: 6/30/03

Pier'Angela Spaccia
 (Applicant's PRINTED name)

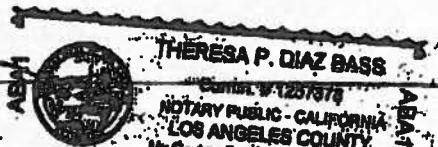
STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

On July 1, 2003, before me, Theresa P. Diaz Bass
 Notary Public, personally appeared Pier'Angela Spaccia
 Proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person, or the entity upon behalf of which the person acted, executed the instrument.

WITNESS my hand and official seal.

SIGNATURE: [Signature]



10/10/2010 10:10:10 AM
10/10/2010 10:10:10 AM
10/10/2010 10:10:10 AM
10/10/2010 10:10:10 AM
10/10/2010 10:10:10 AM

Form W-4 (2003)

Purpose. Complete Form W-4 so that your employer can withhold the correct Federal income tax from your pay. Because your tax situation may change, you may want to refigure your withholding each year.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2003 expires February 16, 2004. See Pub. 503, Tax Withholding and Estimated Tax.

Note: You cannot claim exemption from withholding if: (a) your income exceeds \$780 and includes more than \$290 of unearned income (e.g., interest and dividends) and (b) another person can claim you as a dependent on their tax return.

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 adjust your withholding allowances based on itemized

deductions, certain credits, adjustments to income, or two-earner/two-job situations. Complete all worksheets that apply. However, you may claim fewer (or zero) allowances.

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See line 6 below.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 919, How Do I Adjust My Tax Withholding? for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using

Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax.

Two earners/two jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others.

Nonresident alien. If you are a nonresident alien, see the instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2003. See Pub. 919, especially if your earnings exceed \$125,000 (Single) or \$175,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 for a new social security card.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent **A** _____

B Enter "1" if:
 • You are single and have only one job; or
 • You are married, have only one job, and your spouse does not work; or
 • Your wages from a second job or your spouse's wages (or the total of both) are \$1,000 or less. **B** _____

C Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) **C** _____

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return **D** _____

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above) **E** _____

F Enter "1" if you have at least \$1,500 of child or dependent care expenses for which you plan to claim a credit **F** _____

(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit):
 • If your total income will be between \$15,000 and \$42,000 (\$20,000 and \$65,000 if married), enter "1" for each eligible child plus 1 additional if you have three to five eligible children or 2 additional if you have six or more eligible children.
 • If your total income will be between \$42,000 and \$80,000 (\$65,000 and \$115,000 if married), enter "1" if you have one or two eligible children, "2" if you have three eligible children, "3" if you have four eligible children, or "4" if you have five or more eligible children. **G** _____

H Add lines A through G and enter total here. Note: This may be different from the number of exemptions you claim on your tax return. ▶ **H** _____

For accuracy, complete all worksheets that apply.
 • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
 • If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$35,000, see the Two-Earner/Two-Job Worksheet on page 2 to avoid having too little tax withheld.
 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate ▶ For Privacy Act and Paperwork Reduction Act Notice, see page 2.	OMB No. 1545-0010 2003
1 Type or print your first name and middle initial <i>Pier Angela</i>		Last name <i>Spaccia</i>
2 Your social security number		3 <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a new card. ▶ <input type="checkbox"/>		
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	6 Additional amount, if any, you want withheld from each paycheck	7 I claim exemption from withholding for 2003, and I certify that I meet both of the following conditions for exemption: • Last year I had a right to a refund of all Federal income tax withheld because I had no tax liability and • This year I expect a refund of all Federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶ 7
Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate, or I am entitled to claim exempt status.		
Employer's signature (Form is not valid unless you sign it.) ▶ <i>Pier Angela Spaccia</i>		Date ▶ <i>6/30/03</i>
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) <i>City of Bell, 6330 Pine Avenue, Bell, CA 90201</i>	9 Office code (optional)	10 Employer identification number <i>95: 6000677</i>

Form W-4 (2002)

Page 2

Deductions and Adjustments Worksheet

Note: Use this worksheet only if you plan to itemize deductions, claim certain credits, or claim adjustments to income on your 2002 tax return.

1 Enter an estimate of your 2002 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2002, you may have to reduce your itemized deductions if your income is over \$137,300 (\$68,650 if married filing separately). See Worksheet 3 in Pub. 919 for details.) 1 \$
2 Enter: \$7,850 if married filing jointly or qualifying widow(er) \$6,900 if head of household \$4,700 if single \$3,925 if married-filing separately 2 \$
3 Subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-" 3 \$
4 Enter an estimate of your 2002 adjustments to income, including alimony, deductible IRA contributions, and student loan interest 4 \$
5 Add lines 3 and 4 and enter the total. Include any amount for credits from Worksheet 7 in Pub. 919. 5 \$
6 Enter an estimate of your 2002 nonwage income (such as dividends or interest) 6 \$
7 Subtract line 6 from line 5. Enter the result, but not less than "-0-" 7 \$
8 Divide the amount on line 7 by \$3,000 and enter the result here. Drop any fraction 8
9 Enter the number from the Personal Allowances Worksheet, line H, page 1 9
10 Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earner/Two-Job Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1 10

Two-Earner/Two-Job Worksheet

Note: Use this worksheet only if the instructions under line H on page 1 direct you here.

1 Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet) 1
2 Find the number in Table 1 below that applies to the lowest paying job and enter it here 2
3 If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet. 3

Note: If line 1 is less than line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4-9 below to calculate the additional withholding amount necessary to avoid a year end tax bill.

4 Enter the number from line 2 of this worksheet 4
5 Enter the number from line 1 of this worksheet 5
6 Subtract line 5 from line 4 6
7 Find the amount in Table 2 below that applies to the highest paying job and enter it here 7 \$
8 Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed 8 \$
9 Divide line 8 by the number of pay periods remaining in 2002. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2001. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 \$

Table 1: Two-Earner/Two-Job Worksheet

Table with 8 columns: Married Filing Jointly (wages from LOWEST paying job, Enter on line 2 above) and All Others (wages from LOWEST paying job, Enter on line 2 above). Rows show wage brackets and corresponding numbers for lines 2 and 3.

Table 2: Two-Earner/Two-Job Worksheet

Table with 4 columns: Married Filing Jointly (wages from HIGHEST paying job, Enter on line 7 above) and All Others (wages from HIGHEST paying job, Enter on line 7 above). Rows show wage brackets and corresponding numbers for lines 7 and 8.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may also subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, and the District of Columbia for use in administering their tax laws, and using it in the National Directory of New Hires.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB

control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The time needed to complete this form will vary depending on individual circumstances. The estimated average time is: Recordkeeping, 46 min.; Learning about the law or the form, 13 min.; Preparing the form, 59 min. If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can write to the Tax Forms Committee, Western Area Distribution Center, Rancho Cordova, CA 95743-0001. Do not send the tax form to this address. Instead, give it to your employer.





6330 Pine Avenue
Bell, CA 90201-1291
(213) 588-6211
Fax: (213) 771-9473

PRE-EMPLOYMENT RELEASE AND WAIVER

TO WHOM IT MAY CONCERN:

I hereby authorize any City of Bell or other authorized representative of the City of Bell, bearing this release or a copy of it within one year of its date to obtain any information in your files pertaining to my employment, credit or educational records; including, but not limited to, academic, achievement, attendance, athletic, personal history, performance report background investigations, polygraph examination results, any and all internal affairs investigations and disciplinary records, credit records, medical records or medical information in the files of my current or former employer(s) or any current or former physician(s) or both, which pertain to my employment.

I hereby direct you to release this information upon request of the bearer. This release is executed with full knowledge and understanding that the information is for the official use of the City of Bell.

Consent is granted for the City of Bell, to furnish information described above to their parties in the course of fulfilling its official responsibilities. I further understand that I waive any right or opportunity to read or review any background investigation report prepared by the City of Bell.

I hereby release you as the custodian of such records and any school, college, university or other educational institution, hospital or other repository of medical records, credit bureau, lending institution, consumer reporting agency or retail business establishment including its officers, employees or related personnel both individually and collectively from any and all liability for damage of whatever kind which may at any time result to me, my heirs, family or associates because of compliance with this authorization and request to release information or any attempt to comply with it. Should there be any questions as to the validity of this release, you may contact me as indicated below.

City of Bell



DESIGNATION OF BENEFICIARY

Any person now or hereafter employed by the City of Bell may file with his appointing power a designation of a person who, notwithstanding any other provision of the law, will receive all warrants or checks that would have been payable to the decedent had he survived. A person designated shall claim such warrants or checks from the appointing power.

On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check is entitled to negotiate it as if he were the payee.

You are entitled to change the designation as you deem necessary. This person may be designated by your filling in the following:

To the appointed authority:

I, Pier Angela Spaccia Do hereby designate
Sean-Thomas F. Spaccia Sheriff to receive all warrants or
 checks at the time of my death, due me by the City of Bell.

Pier Angela Spaccia
 Signature

6/30/03
 Date

City of Bell



Acknowledgement Form

Please complete and return this form to the Personnel Division of Administrative Services. If you have any questions regarding the Employee Safety Handbook and/or the Drug and Alcohol Abuse Policy, please contact Theresa Diaz, extension 217.

On 6/30/03, I received a copy of the City of Bell's Employee Safety Handbook and a copy of the City of Bell's Drug and Alcohol Abuse Policy. I accept Responsibility for reading and understanding these two handbooks. If I have any questions, I will contact the appropriate personnel for clarification.

I understand that a copy of this acknowledgement form will be placed in my Personnel File located in the Personnel Division of Administrative Services.

Employee
Signature *Frank Angel Spaura* Date 6/30/03



6330 Pine Avenue
 Bell, CA 90201-1291
 (213) 588-6211
 Fax: (213) 771-9473

TO WHOM IT MAY CONCERN:

I, Pier'Angela Spaccia, hereby authorize the release to the City of Bell any and all records maintained by the California Department of Motor Vehicles (DMV) pertaining to me. This includes, but is not limited to, records requested under California Vehicle Code Section 1808.1

My California Diver License is: _____
 Expiration Date: 9-19-05

I understand that these records may contain personal or potentially embarrassing information. I understand that I may be giving up certain rights to keep these records private. I understand that information in these records may result in my disqualification from further consideration as an employee of or employment by the City of Bell

I HAVE READ AND UNDERSTAND THIS DOCUMENT. _____

Dated: 6/30/03

Signed: Pier'Angela Spaccia

Print your name: Pier'Angela Spaccia

WITNESS: [Signature]

**EMPLOYEE PRE-SELECTION OF PHYSICIAN
FOR INDUSTRIAL INJURY OR ILLNESS**



To: Human Resources/Personnel Dept.

Employee Name: Pier'Angela Spaccia

Department: _____

Date: 6/30/03

Subject: **Pre-Selection of Physician for Work-related (Industrial) Injury or Illness**

I hereby exercise my right to choose a physician from the initial date of a work-related injury or illness. I certify that the physician named below is my personal physician, has previously directed my medical treatment, and retains my medical records. After I submit this notice, I request that I be allowed to receive treatment by my personal physician. I have provided a copy of this document to my personal physician.

Name of Physician: _____

Address: _____

Phone No: () _____

Employee Signature

I elect to use my employer's designated medical providers for a work-related injury or illness.

Pier'Angela Spaccia
Employee Signature

Debt Service Schedule for Payroll Loan -Year 2008**P'IER ANGELA SPACCIA #148**

Monthly Vacation Accrual Rate (hrs) 21.3
 Annual Total Hours of Vacation Accrued 255.6
 Biweekly Vacation Hours 9.84
 Hourly Rate

Annual LAIF interest rate/Jan-March 2008
 Effective biweekly interest rate 0.001607692
 Annual LAIF interest rate/April-June 2008
 Effective biweekly interest rate 0.001196154
 Annual LAIF interest rate/July-Sept 2008
 Effective biweekly interest rate 0
 Annual LAIF interest rate/Oct-Dec 2007
 Effective biweekly interest rate 0.001907692

# of Pmts	PAY PERIOD ENDING DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST	BI-WEEKLY PRINCIPAL
				85-521-1000-0199	
1	01/06/08	51,803.50	2,226.49	98.83	2,127.66
2	01/20/08	49,675.83	3,722.49	94.77	3,627.72
3	02/03/08	46,048.11	3,722.49	87.85	3,634.64
4	02/17/08	42,413.46	3,722.49	80.91	3,641.58
5	03/02/08	38,771.89	3,722.49	73.96	3,648.53
6	03/16/08	35,123.36	3,722.49	67.00	3,655.49
7	03/30/08	31,467.88	3,722.49	60.03	3,662.46
8	04/13/08	27,805.42	3,722.49	44.70	3,677.79
9	04/27/08	24,127.63	3,722.49	38.79	3,683.70
10	05/11/08	20,443.93	3,722.49	32.87	3,689.62
11	05/25/08	16,754.31	3,722.49	26.94	3,695.54
12	06/08/08	13,058.76	3,722.49	20.99	3,701.50
13	06/22/08	9,357.27	3,722.49	15.04	3,707.45
14	07/06/08	5,649.82	5,398.47	9.08	5,389.39
15	07/20/08	260.43	260.75	0.31	260.44
16	08/03/08	(0.00)			
17	08/17/08				
18	08/31/08				
19	09/14/08				
20	09/28/08				
21	10/12/08				
22	10/26/08				
23	11/09/08				
24	11/23/08				
25	12/07/08				
26	12/21/08				

Balance @ end of 2008 \$

Total Payments to Reimburse City

\$52,555.59 \$ 752.08 \$51,803.50

From: Pier Angela Spaccia

For: LOAN REIMBURSEMENT- PAYROLL ENDING

7/20/2008

Acct # Interest Payment- 85-521-1000-0199 \$ 0.31

Acct # Principal Payment- 85-521-1000-0199 260.44

\$ 260.75

Debt Service Schedule for Payroll Loan -Year 2007**P'IER ANGELA SPACCIA #148**

Monthly Vacation Accrual Rate (hrs)	21.3
Annual Total Hours of Vacation Accrued	255.6
Biweekly Vacation Hours	9.84
Hourly Rate	13.00
Annual LAIF Interest rate/Jan-March 2007	0.001988462
Effective biweekly interest rate	0.001988462
Annual LAIF interest rate/April-June 2007	0.002011538
Effective biweekly interest rate	0.002011538
Annual LAIF interest rate/July-Sept 2007	0.002015385
Effective biweekly interest rate	0.002015385
Annual LAIF Interest rate/Oct-Dec 2006	0.001965385
Effective biweekly interest rate	0.001965385

# of Pmts	PAYROLL DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST 85-521-1000-0199	BI-WEEKLY PRINCIPAL
1	01/07/07	66,633.63	994.41	130.96	863.45
2	01/21/07	65,770.18	994.41	129.26	865.15
3	02/04/07	64,905.04	994.41	127.56	866.85
4	02/18/07	64,038.19	994.41	125.86	868.55
5	03/04/07	63,169.64	994.41	124.15	870.26
		62,299.38	994.41	122.44	871.97
		61,427.41	994.41	120.73	873.68
		60,553.73	994.41	120.41	874.00
		59,679.73	994.41	118.67	875.74
		58,803.99	994.41	116.93	877.48
		57,926.51	994.41	115.18	879.22
		57,047.30	994.41	113.44	880.97
		56,166.32	994.41	111.68	882.73
		55,283.60	50,453.83	109.93	50,343.90
15	07/22/07	76,939.70	2,226.49	154.77	2,071.72
16	08/05/07	74,867.97	2,226.49	150.60	2,075.89
17	08/19/07	72,792.08	2,226.49	146.42	2,080.07
18	09/02/07	70,712.02	2,226.49	142.24	2,084.25
19	09/16/07	68,627.77	2,226.49	138.05	2,088.44
20	09/30/07	66,539.32	2,226.49	133.85	2,092.64
21	10/14/07	64,446.68	2,226.49	129.88	2,096.61
22	10/28/07	62,350.08	2,226.49	125.66	2,100.83
23	11/11/07	60,249.25	2,226.49	121.43	2,105.06
24	11/25/07	58,144.18	2,226.49	117.18	2,109.31
25	12/09/07	56,034.87	2,226.49	112.93	2,113.56
26	12/23/07	53,921.32	2,226.49	108.67	2,117.82

Employee paid \$50,453.83 using her sick and vacation accruals leaving a balance of \$4,829.77. Employee was granted a 4th admin agreement loan in the amount of \$72,000.0 for a balance of \$76,829.77

Balance @ end of 2007 \$ 51,803.50

Total Payments to Reimburse City

\$90,099.04 \$3,268.90 \$72,094.31

From: Pier'Angela Spaccia

For: LOAN REIMBURSEMENT- PAYROLL ENDING 12/23/2007

Acct # Interest Payment- 85-521-1000-0199 \$ 108.67

Acct # Principal Payment- 85-521-1000-0199 2,117.82

\$ 2,226.49

Debt Service Schedule for Payroll Loan -Year 2006**P'IER ANGELA SPACCIA #148**

Monthly Vacation Accrual Rate (hrs) 21.3
 Annual Total Hours of Vacation Accrued 255.6
 Biweekly Vacation Hours 9.84
 Hourly Rate \$ 98.56

Annual LAIF Interest rate/Jan-March 2006
 Effective biweekly interest rate 0.00155
 Annual LAIF Interest rate/April-June 2006
 Effective biweekly interest rate 0.001742308
 Annual LAIF Interest rate/July-Sept 2006
 Effective biweekly interest rate 0.001896154
 Annual LAIF Interest rate/Oct-Dec 2006
 Effective biweekly interest rate 0.001396154

Increased
hourly rate
to \$98.56
as of 7/1/06

# of Pmts	PAYROLL DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST	BI-WEEKLY PRINCIPAL
					85-521-2000-0199
1	01/08/06	74,243.19	875.20	103.65	771.55
2	01/22/06	73,471.65	875.20	102.58	772.62
3	02/05/06	72,699.02	875.20	101.50	773.70
4	02/19/06	71,925.32	875.20		
5	03/05/06	71,150.54	875.20		
6	03/19/06	70,374.68	875.20		
7	04/02/06	69,597.73	875.20		
8	04/16/06	68,819.70	875.20		
9	04/30/06	68,051.17	875.20	105.48	769.72
10	05/14/06	53,281.45	875.20	82.50	792.61
11	05/28/06	52,488.84	875.20		83
12	06/11/06	51,695.01	875.20		07
13	06/25/06	50,899.93	875.20		31
14	07/09/06	50,103.63	1,117.42		76
15	07/23/06	49,063.87	969.82		34
16	08/06/06	48,179.53	969.82	83.94	885.88
17	08/20/06	47,293.66	969.82	82.40	887.42
18	09/03/06	46,406.24	969.82	80.85	888.97
19	09/17/06	73,517.27	969.82	128.09	841.73
20	10/01/06	72,675.54	1,043.61	126.62	916.99
21	10/15/06	71,758.55	969.81	136.07	833.74
22	10/29/06	70,924.81	969.81	134.48	835.33
23	11/12/06	70,089.48	994.41	132.90	861.51
24	11/26/06	69,227.97	994.41	131.27	863.14
25	12/10/06	68,364.83	994.41	129.63	864.78
26	12/24/06	67,500.05	994.41	127.99	866.42

Balance @ end of 2006 \$ 66,633.63

Total Payments to Reimburse City

\$24,304.99 \$2,695.42 \$15,567.65

From: Pier'Angela Spaccia

For: LOAN REIMBURSEMENT- PAYROLL ENDING

12/24/2006

Acct # Interest Payment- 85-521-2000-0199 \$ 128.14

Acct # Principal Payment- 85-521-2000-0199 \$ 866.27

\$ 994.41

Debt Service Schedule for Payroll Loan -Year 2005

P'IER ANGELA SPACCIA #148

Monthly Vacation Accrual Rate (hrs)	8	21.3	~Hourly and Vacation
Annual Total Hours of Vacation Accrued	96	255.6	Accrual Rate Increased
Biweekly Vacation Hours	3.70	9.84	as of 7/1/05
Hourly Rate	6.250	6.250	

Annual LAIF Interest rate/Jan-March 2005	0.000915385
Effective biweekly Interest rate	0.000915385
Annual LAIF Interest rate/April-June 2005	0.001096154
Effective biweekly Interest rate	0.001096154
Annual LAIF Interest rate/July-Sept 2005	0.001223077
Effective biweekly Interest rate	0.001223077
Annual LAIF Interest rate/Oct-Dec 2004	0.000769231
Effective biweekly Interest rate	0.000769231

# of Pmts	PAYROLL DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST	BI-WEEKLY PRINCIPAL
				86-521-2000-0199	87-521-2000-0199
1	01/09/05	72,805.89	231.25	56.00	175.25
2	01/23/05	72,630.64	231.25	55.87	175.38
3	02/06/05	72,455.26	231.25	55.73	175.52
4	02/20/05	72,279.75	231.25	55.60	175.65
5	03/06/05	72,104.10	231.25	55.46	175.79
6	03/20/05	71,928.31	231.25	55.33	175.92
7	04/03/05	71,752.39	231.25	55.19	176.06
8	04/17/05	71,576.33	231.25	65.52	165.73
9	05/01/05	71,410.60	231.25	65.37	165.88
10	05/15/05	71,244.72	231.25	65.22	166.03
		71,078.69	231.25	65.06	166.18
		70,912.51	231.25	64.91	166.34
		70,746.18	231.25	64.76	166.49
		70,579.69	875.19	64.61	810.59
15	07/24/05	69,769.10	875.19	76.48	798.72
16	08/07/05	68,970.38	875.20	75.60	799.60
17	08/21/05	68,170.78	875.20	74.76	800.44
18	09/04/05	67,370.34	875.20	73.85	801.35
19	09/18/05	66,568.99	875.20	72.97	802.23
20	10/02/05	65,766.76	875.20	72.09	803.11
21	10/16/05	64,963.65	875.20	79.47	795.73
22	10/30/05	64,167.92	875.20	78.48	796.72
23	11/13/05	77,371.20	875.20	94.63	780.57
24	11/27/05	76,590.63	875.20	93.68	781.52
25	12/11/05	75,809.11	875.20	92.72	782.48
26	12/25/05	75,026.63	875.20	91.76	783.44

On 11/4/05 a second loan for \$14,000.00 was granted. Existing balance was of \$64,167.92 + 14,000.00 = New balance \$78,167.92

Balance @ end of 2005 \$ 74,243.19

Total Payments to Reimburse City

\$14,383.84	\$1,821.13	\$12,562.70
--------------------	-------------------	--------------------

From: Pier Angela Spaccia

For: LOAN REIMBURSEMENT- PAYROLL ENDING

12/25/2005

Acct # Interest Payment- 86-521-2000-0199	\$	45.91	
Acct # Interest Payment- 87-521-2000-0199		45.91	
Acct # Principal Payment- 86-521-2000-0199		391.69	
Acct # Principal Payment- 87-521-2000-0199		391.69	
	\$	875.20	

City of Bell ~ Payroll Loan Reimbursement
YEAR 2003

Employee Name Pier'Angela Spaccia

Monthly Vacation Accrual Rate (hrs) 8
 Annual Total Hours of Vacation Accrued 96
 Biweekly Vacation Hours 3.69
 Hourly Rate 19.1875

Annual LAIF interest rate/Oct-Dec. 0.00%
 Effective biweekly interest rate 0
 Annual LAIF interest rate/Jan-March 0.00%
 Effective biweekly interest rate 0
 Annual LAIF interest rate/April-June 0.99%
 Effective biweekly interest rate 0
 Annual LAIF interest rate/July-Sept 0.63%
 Effective biweekly interest rate 0.000626923

<u># of</u> <u>Pmts</u>	<u>PAYROLL</u> <u>DATE</u>	<u>LOAN</u> <u>AMOUNT</u>	<u>BIWEEKLY</u> <u>PAYMENTS</u>	<u>BIWEEKLY</u> <u>INTEREST</u>	<u>BIWEEKLY</u> <u>PRINCIPAL</u>
				86-521-2000-0199	
				87-521-2000-0199	
1	11/07/03	77,500.00	181.50	48.59	132.92
2	11/21/03	77,387.08	181.50	48.50	133.00
3	12/05/03	77,234.09	181.50	48.42	133.08
4	12/19/03	77,101.00	181.50	48.34	133.17
	Balance @ end of 2003	\$ 76,967.84			
	Total Payments to Reimburse City		\$ 726.01	\$ 193.85	\$ 632.16

Cash Disbursements

From: Pier'Angela Spaccia
For: REIMBURSEMENT OF LOAN FOR PAY OF 12/19/2003

Acct # Interest Payment- 87-521-2000-0199	\$ 24.28
Acct # Interest Payment- 86-521-2000-0199	24.28
Acct # Principal Payment- 87-521-2000-0199	66.45
Acct # Principal Payment- 86-521-2000-0199	66.49
	\$ 181.50

ADMINISTRATIVE AGREEMENT

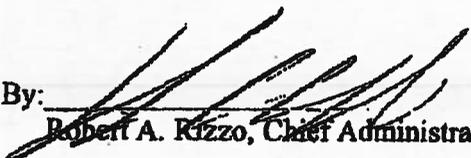
This Administrative Agreement ("Agreement"), is made and entered into this 1st day of March, 2010, by and between the CITY OF BELL ("City") and Pier'Angela Spaccia ("Employee"), Assistant CAO for the City of Bell.

NOW, THEREFORE, CITY AND EMPLOYEE agree to the following:

1. Employee shall be entitled to a cash advance, from the City, an amount not to exceed \$130,000 (One Hundred Thirty Thousand Dollars).
2. The Agreement is subject to the following provisions:
 - a) Employee assigns to City any rights under the Agreement or Federal, State or local law to collect from wages earned up to the unpaid balance plus accrued interest;
 - b) Repayment of the cash advance shall bear interest that shall compound biweekly and accrue at a rate equal to the annual interest rate of the Local Agency Investment Fund (LAIF) administered by the California State Treasurer for the quarter prior to the disbursement of the cash advance. The interest rate to be used after disbursement of the advance shall be the LAIF interest rate prior to the quarter of the payment date;
 - c) The term of the advance shall commence on the date of disbursement of the cash advance and shall continue until the date the repayment is fully satisfied by payment as provided herein;
 - d) Payment of the loan and the accumulated interest should be paid in full to the City no later than May 28, 2010;
 - e) In the event of Employee's termination, repayment of the advance outstanding shall immediately become due and payable;
 - f) In the event of Employee's termination, if repayment of the advance is not fully satisfied by the employee's the wages earned; employee should obtain a conventional loan to meet the aforementioned obligation to the City;
- 2) City and Employee hereby acknowledge and agree that this Agreement is in full force and effect. All capitalized terms not specifically defined herein, shall have the same meaning ascribed to them in the Agreement.

IN WITNESS WHEREOF, the parties have caused this Administrative Agreement to be executed as follows:

“City”
CITY OF BELL, CALIFORNIA

By: 
Robert A. Rizzo, Chief Administrative Officer

“Employee”


Pier'Angela Spaccia, Assistant to CAO

**MEMO****July 19, 2007**

**TO: Rebecca Valdez,
Account Clerk**

**FROM: Ana L. Hernandez, ~~✍~~
Management Analyst**

RE: Pier Angela Spacca #148

Due to the salary increase for Pier Angela Spacca on 7/1/07 and the vacation accrual increase, please change the bi-weekly miscellaneous payroll deduction for her administrative agreement repayment to \$2,226.49 effective pay period ending 7/22/07.

If you have any questions, please contact me at ext 224. Thank you.

PIER ANGELO SPACCIA #148

Monthly Vacation Accrual Rate (hrs) 21.3
 Annual Total Hours of Vacation Accrued 255.6
 Biweekly Vacation Hours 19.69
 Hourly Rate \$15.00

Annual LAIF Interest rate/Jan-March 2007 0.001988462

Effective biweekly interest rate 0.001988462

Annual LAIF Interest rate/April-June 2007 0.002011538

Effective biweekly interest rate 0.002011538

Annual LAIF Interest rate/July-Sept 2007 0.001965385

Effective biweekly interest rate 0.001965385

Annual LAIF Interest rate/Oct-Dec 2006 0.001965385

Effective biweekly interest rate 0.001965385

# of Pmts	PAYROLL DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST	BI-WEEKLY PRINCIPAL
				85-521-1000-0199	
1	01/12/07	66,712.83	994.41	131.12	863.29
2	01/26/07	65,849.53	994.41	129.42	864.99
3	02/09/07	64,984.54	994.41	127.72	866.69
4	02/23/07	64,117.85	994.41	126.02	868.39
5	03/09/07	63,249.46	994.41	124.31	870.10
6	03/23/07	62,379.36	994.41	122.60	871.81
7	04/06/07	61,507.55	994.41	122.31	872.10
8	04/20/07	60,635.44	994.41	120.57	873.84
9	05/04/07	59,761.61	994.41	118.83	875.58
10	05/18/07	58,886.03	994.41	117.09	877.32
11	06/01/07	58,008.71	994.41	115.35	879.05
12	06/15/07	57,129.66	994.41	113.60	880.81
13	06/29/07	56,248.85	994.41	111.85	882.56
14	07/13/07	55,366.29	50,453.83	111.37	50,342.46
15	07/27/07	77,023.83	2,226.49	154.94	2,071.55
16	08/10/07	74,952.28	2,226.49	150.77	2,075.72
17	08/24/07	72,876.56	2,226.49	146.59	2,079.90
18	09/07/07	70,796.66	2,226.49	142.41	2,084.08
19	09/21/07	68,712.58	2,226.49	138.22	2,088.27
20	10/05/07	66,624.31	2,226.49	-	2,226.49
21	10/19/07	64,537.82	2,226.49	-	2,226.49
22	11/02/07	62,451.33	2,226.49	-	2,226.49
23	11/16/07	59,944.84	2,226.49	-	2,226.49
24	11/30/07	57,718.35	2,226.49	-	2,226.49
25	12/14/07	55,491.86	2,226.49	-	2,226.49
26	12/28/07	53,265.37	2,226.49	-	2,226.49

Balance @ end of 2007 \$ 51,038.88

Total Payments to Reimburse City

\$90,099.04 \$ 2,425.08 \$72,088.52

Cash Received

From: Pier Angela Spaccia

For: LOAN REIMBURSEMENT- PAYROLL ENDING

7/22/2007

Acct # Interest Payment- 85-521-1000-0199 \$ 154.94

Acct # Principal Payment- 85-521-1000-0199 2,071.55

\$ 2,226.49

7/19/2007

B051966

ACTION = INQUIRE EMPLOYEE # 148 , CONTINUED

		<u>AUTOM</u>	<u>C DISTRIBUTION</u>
		ACCOUNT #	PERCENT
VAC ACCR RATE	19.6960		
SICK ACCR RATE	7.3920	77 0852550180110	5.00
FLOAT ACCR RATE	40.0000	78 0952550190110	5.00
VAC HRS BAL	54.4240	79 1052550390110	5.00
(SICK 100% BAL)	391.7760	80 4552537400110	5.00
FLOAT HRS BAL	40.0000	81 8552110000110	80.00
COMP HRS BAL	0.0000	82	
ADJUST W2	3727.67	83	
SICK PERSNL HRS	0.00	84	

**MEMO**

July 10, 2006

TO: Theresa Diaz,
Management Analyst

FROM: Ana L. Hernandez,
Management Analyst

RE: Pier Angela Spaccia #148

Due to the salary increase for Pier Angela Spaccia on 7/1/06, please change the bi-weekly miscellaneous payroll deduction for her cash advance repayment from \$875.20 to \$969.82 effective pay period ending 7/09/06.

If you have any questions, please contact me at ext 224. Thank you.

TIME CARDS FOR DATE (MMDDYY): 07/09/06

EMP NO. SEQ# EMP ME
148 PIER, ANGELA SPACCIA

-- GL# FUNC NO TYPE WORK ---
01101 10
9=Comp earned

HOURS HRLY RATE EARNINGS 10=Regular 40=Holiday
4.92 98.5581 484.91 11=Retro 44=Flt Hol(PERS)

IS EMPLOYEE:

SALARY 12=Educ 45=Float Hol
7884.65 13=Diff 50=Vacation
HOURS 0 EARNINGS 0.00 14=4850 60=Sick 100%

15=IOD/Wrk Cmp 61=Sick 75%
18=Educ(Nontxbl) 62=Sick 50%
19=Bereavement 63=Sick persnl
20=Overtime 80=Standby
30=CRA (PERS) 81=Court
31=SPA (PERS) 90=Training
32=PLN (PERS) 91=Uniform
33=CHA (PERS) 95=Misc
34=PFA (PERS) 96=Life insur

ESTART ENTRY	NEXT EMPLOYEE	CHANGE DATE	EXIT
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**MEMO**

July 20, 2004

TO: Theresa Diaz,
Management Analyst

FROM: Ana L. Hernandez,
Management Analyst

RE: **Pier'Angela Spaccia #148**

Due to the salary increase for Pier'Angela Spaccia on 7/1/04, please change the miscellaneous payroll deduction for her cash advance from \$181.50 to \$231.25 effective pay period ending 7/25/04. Thank you.

Debt Service Schedule for Payroll Loan - Year 2004**PIER ANGELA SPACCIA #148**

Monthly Vacation Accrual Rate (hrs)	8	7/1/2004
Annual Total Hours of Vacation Accrued	96	
Biweekly Vacation Hours	3.69	
Hourly Rate		\$ 62.50
Annual LAIF interest rate/Oct-Dec 2003		
Effective biweekly interest rate	0.0006	
Annual LAIF interest rate/Jan-March		
Effective biweekly interest rate	0.000565385	
Annual LAIF interest rate/April-June 2004		
Effective biweekly interest rate	0.000553846	
Annual LAIF interest rate/July-Sept 2003		
Effective biweekly interest rate	0.000626923	

# of Pmts	PAYROLL DATE	LOAN AMOUNT	BI-WEEKLY PAYMENTS	BI-WEEKLY INTEREST	BI-WEEKLY PRINCIPAL
				86-521-2000-0199	87-521-2000-0199
1	01/02/04	76,967.84	181.50	48.25	133.25
2	01/16/04	76,834.59	181.50	46.10	135.40
3	01/30/04	76,699.19	181.50	46.02	135.48
4	02/13/04	76,563.71	181.50	45.94	135.56
5	02/27/04	76,428.14	181.50	45.86	135.64
6	03/12/04	76,292.50	181.50	45.77	135.73
7	03/26/04	76,156.77	181.50	45.69	135.81
8	04/09/04	76,020.96	181.50	42.98	138.52
9	04/23/04	75,882.44	181.50	42.90	138.60
10	05/07/04	75,743.84	181.50	42.82	138.68
11	05/21/04	75,605.16	181.50	42.75	138.75
12	06/04/04	75,466.41	181.50	42.67	138.83
13	06/18/04	75,327.58	181.50	42.59	138.91
14	07/02/04	75,188.67	181.50	41.64	139.86
15	07/16/04	75,048.81	231.25	41.57	189.68
16	07/30/04	74,859.12	231.25	41.46	189.79
17	08/13/04	74,669.33	231.25	41.36	189.89
18	08/27/04	74,479.44	231.25	41.25	190.00
19	09/10/04	74,289.44	231.25	41.14	190.11
20	09/24/04	74,099.33	231.25	41.04	190.21
21	10/08/04	73,909.12	231.25		231.25
22	10/22/04	73,677.87	231.25		231.25
23	11/05/04	73,446.62	231.25		231.25
24	11/19/04	73,215.37	231.25		231.25
25	12/03/04	72,984.12	231.25		231.25
26	12/17/04	72,752.87	231.25		231.25
Balance @ end of 2003 \$ 74,099.33					
Total Payments to Reimburse City			<u>\$ 5,316.03</u>	<u>\$ 869.80</u>	<u>\$ 2,868.50</u>

From:	Pier'Angela Spaccia	
For:	REIMBURSEMENT OF LOAN FOR PAY OF	<u>7/16/2004</u>
Acct #	Interest Payment- 86-521-2000-0199	\$ 20.79
Acct #	Interest Payment- 87-521-2000-0199	20.78
Acct #	Principal Payment- 86-521-2000-0199	94.84
Acct #	Principal Payment- 87-521-2000-0199	94.84
		<u>\$ 231.25</u>

7/20/2004

B051971

*** POSTING DETAIL ***

INCTION: INQUIRE EMPLOYEE#: 148

NAME (LAST, FIRST)	SPACCIA	, PIER'ANGELA	15	DATE HIRED (FT)	:070103
CLASSIFICATION:	8810		16	DATE NEXT REVIEW:	
TITLE:	ASSISTANT TO CAO		17	DATE STEP INCR:	070104
SEX (M/F):	F		18	STEP:	
RATE/HR:	62.5000		19	DATE OF BIRTH:	091958
RATE/SEMI-MO:	0.00		20	DATE HIRED (PARTTIME)	
RATE/MO (STEP):	10833.33		21	DATE TERMINATED:	
RATE/YR:	0.00	22	BANK 1 ACCT#:	0635182470	*ACH CD: 1
100% SICK BAL:	99.7920	23	BANK 2 ACCT#:		*ACH CD: 0
75% SICK BAL:	112.0000	24	BANK 3 ACCT#:		*ACH CD: 0
50% SICK BAL:	112.0000	25	ADD'L INFO:		
DRIVERS LIC#:		26	ADD'L INFO:		
HOME TELE#:		27	ADD'L INFO:		
		28	TELEPHONE#:	CELL-	...
		29	TELEPHONE#:	WCELL-	
			*ACH CD:	CHECKING	SAVINGS
			ACTIVE =	1	2
			ON HOLD =	10	20
			PRENOTE =	19	29

PRINT

NEXT
RECORD

EXIT


MEMO

October 29, 2003

**TO: Theresa Diaz,
Management Analyst**

**FROM: Ana L. Hernandez,
Management Analyst**

RE: Pier'Angela Spaccia #148

Per the Employment Agreement, please add a miscellaneous deduction in the amount of \$181.50 for her payroll loan repayment effective PPE 11/02/03. Her payroll loan was approved on October 15 2003, attached you will find the supporting documentation.

Thank you.

City of Bell ~ Payroll Loan Reimbursement

YEAR 2003

Employee Name Pier'Angela Spaccia

Monthly Vacation Accrual Rate (hrs) 8
 Annual Total Hours of Vacation Accrued 96
 Biweekly Vacation Hours 3.69
 Hourly Rate ██████████
 Annual LAIF interest rate/Oct-Dec. ██████████
 Effective biweekly interest rate 0
 Annual LAIF interest rate/Jan-March ██████████
 Effective biweekly interest rate 0
 Annual LAIF interest rate/April-June ██████████
 Effective biweekly interest rate 0
 Annual LAIF interest rate/July-Sept ██████████
 Effective biweekly interest rate 0.000626923

<u># of</u> <u>Pmts</u>	<u>PAYROLL</u> <u>DATE</u>	<u>LOAN</u> <u>AMOUNT</u>	<u>BIWEEKLY</u> <u>PAYMENTS</u>	<u>BIWEEKLY</u> <u>INTEREST</u> 87-521-2000-0199	<u>BIWEEKLY</u> <u>PRINCIPAL</u> 87-521-2000-0199
1	11/07/03	77,500.00	181.50	48.59	132.92
2	11/21/03	77,367.08	181.50	48.50	133.00
3	12/05/03	77,234.09	181.50	48.42	133.08
4	12/19/03	77,101.00	181.50	48.34	133.17
Balance @ end of 2003 \$ 76,967.84					
Total Payments to Reimburse City			<u>\$ 726.01</u>	<u>\$ 193.85</u>	<u>\$ 532.16</u>

From: Pier'Angela Spaccia
 For: REIMBURSEMENT OF LOAN FOR PAY OF 11/7/2003
 Acct# Interest Payment- 87-521-2000-0199 \$ 24.28
 Acct# Interest Payment- 88-521-2000-0199 24.28
 Acct # Principal Payment- 87-521-2000-0199 66.45
 Acct # Principal Payment- 88-521-2000-0199 66.49
 \$ 181.50

10/29/2003

B051974

FUNCTION = INQUIRE EMPLOYEE # 148 , CONTINUED

2	VAC	ACCR RATE	3.6960	
3	SICK	ACCR RATE	3.6960	77
4	FLOAT	ACCR RATE	20.0000	78
5	VAC	HRS BAL	29.5680	79
-	(SICK	100% BAL)	29.5680	80
7	FLOAT	HRS BAL	20.0000	81
8	COMP	HRS BAL	0.0000	82
9	ADJUST	W2	0.00	83
0	SICK	PERSNL HRS	0.00	84

AUTOMATIC DISTRIBUTION

ACCOUNT #	PERCENT
8652120000110	50.00
8752120000110	50.00

AUTOMATIC EARNINGS

FREQ	TYPE	WRK	AMOUNT	ACCOUNT #
0	0		0.00	87
0	0		0.00	88
0	0		0.00	89
0	0		0.00	90
0	0		0.00	91
0	0		0.00	92